

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**  
**MEETING MINUTES**  
**October 14 and 15, 2009**  
**Lake Natoma Inn**  
**702 Gold Lake Drive**  
**Folsom, CA 95630**

**CMHPC Members Present:**

Dale Mueller, Chair	Karen Hart
Gail Nickerson, Chair-Elect	Patrick Henning
Beverly Abbott	Carmen Lee
Jim Alves	Barbara Marquez
Dennis Beaty	Barbara Mitchell
Renee Becker	Jennie Montoya
Jim Bellotti	Joe Mortz
Lin Benjamin	Mark Refowitz
Shebuah Burke	John Ryan
Sophie Cabrera	Daphne Shaw
Andrew Cavagnaro	Linne Stout
Doreen Cease	Stephanie Thal
Adrienne Cedro-Hament	Monica Wilson
George Fry, Jr.	Curtis Boewer (Friday)
Luis Garcia	

**Staff Present:**

Linda Brophy	Andi Murphy
Karen Hudson	Narkesia Swangian
Brian Keefer	Tracy Thompson

**Wednesday, October 14, 2009**

**1. Welcome and Introductions**

*Chair Mueller* called the meeting to order at 1:03 p.m. Planning Council Members and guests in the audience introduced themselves.

*Chair Mueller* presented a Certificate of Appreciation to *Jim Bellotti* in recognition of outstanding contributions as a representative of the California Department of Education, and as a member and participant of the Children and Youth Subcommittee and Quality Improvement Committee. *Mr. Bellotti* thanked the Council for the great opportunity to be a part of Planning Council meetings.

## 2. Update on Federal Parity Statute

*Sheree Kruckenberg*, Vice President, Behavioral Health, California Hospital Association, provided the update. Some highlights:

- The federal Mental Health Parity and Addiction Equity Act of 2008 (“the Act”) was included in the Emergency Economic Stabilization Act of 2008 and signed into law on October 3, 2008. It is part of HR 1424. It goes into effect for most plans on January 1, 2010.
- The Act required three Departments -- Labor, Health and Human Services, and Treasury -- to write regulations. In April of 2009 Health and Human Services released a Request for Information to solicit comments about the regulations from stakeholders and others. Over 400 comments were submitted, from California and other states.
- Because of the large number of responses, Health and Human Services realized they would not be able to assimilate all the comments and write the regulations by October 3, 2009, as prescribed by the Act. The October deadline has been extended to January 2010 to allow time to incorporate the large number of comments received.
- As part of the Act, Executive Order 12866 requires solicited comments to assess the anticipated costs of rulemaking; to analyze the economic impact on small entities; and to estimate the time and costs incurred for collection of information.
- All the proposed rules and comments can be found in the Federal Register; go to [www.gpoaccess.gov/FR/](http://www.gpoaccess.gov/FR/) to sign up for daily updates.
- The Act builds upon the existing 1996 Parity Act, which remains in effect through December 31, 2009, and which required plans to provide comparable annual or lifetime dollar limits for mental health and physical health services.
- The Act amends the 1996 Parity Act to include substance use disorders (SUDs).
- The Act also amends the Employee Retirement Income Security Act of 1974 (ERISA); the Internal Revenue Code of 1986; and the Public Health Services Act.
- The word “Parity” in the new Act means equal benefits, equal limits, equal cost sharing, and equal coverage for mental health/substance abuse and physical health conditions.
- Equity coverage for both mental health and addictions treatment services applies to all financial requirements, including deductibles, co-payments, co-insurance, and out-of-pocket expenses; and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.

- If a group health plan (or coverage) provides out-of-network coverage for medical and/or surgical benefits, it must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits.
- The Act modifies the original definition of mental health benefits created by the 1996 Parity Act to include a definition of substance use disorder benefits.
- The Act requires that criteria for medical necessity determinations be made available upon request; however, it does not provide a definition of medical necessity.
- Reasons for denials must be made available upon request, and in accordance with regulations.
- The Act preserves state law and current Health Insurance Portability and Accountability Act (HIPAA) preemption standards apply.
- There is a small employer exemption for employers with 50 or fewer employees.
- A cost exemption is also available, but only for one year.
- The Act does not apply to the individual insurance market or to Medicare.
- The Act does not mandate that covered plans provide a mental health/SUD benefit or that all mental health and SUD conditions are covered.
- To properly evaluate the Act, a Compliance Report will be due in 2012, and every two years after that. The Labor Secretary shall submit the report to Congress.
- The General Accounting Agency (GAO) will provide a report to Congress within three years, and an additional report after five years, to ensure that parity is happening as it was described in the Act.
- Covered entities include group plans that are sponsored by private-sector employers and unions; church-sponsored plans; Medicaid managed care; some State Children's Health Insurance Program (SCHIP) plans; and some state and local health plans.
- It is hoped that one impact of the law will be that, for in-network providers, parity in financial requirements and treatment limitations will increase the number of potential clients seeking services. Other types of providers may see this as a business opportunity and develop their capacity to provide MH and SUD services.

- The Act does not require every diagnosis of a MH or SUD nature to be covered by a plan. It does say that if you offer mental health benefits, you must offer MH and SUD benefits on parallel with physical health benefits.

**Questions/Answers/Comments with Ms. Kruckenberg**

*Joe Mortz:* I'm assuming, with federal health reform, the Parity Act is going to process into reform, into whatever is being done at the federal level?

**Answer:** Well, it's not going away. That would take an Act of Congress. This is not a part of health reform -- it happened prior to that process; nor have we received any indication that it will become a part of that process.

*Joe Mortz:* Does this require a change in licensing of practitioners for substance abuse? Would other non-licensed providers be recognized in California?

**Answer:** This doesn't impact either of those in California at all.

*Barbara Marquez:* We received a memo stating that, due to the federal parity law, plans available now are being cut and the deductible levels are being raised on everything; and then, effective when your policy renews, we will not be able to get the same group plans that we have now. Have you received any information on that?

**Answer:** We have not heard anything about that. I'd be very interested in seeing those. Also, if you know of anyone that receives a notice that implies that a plan is going to cut benefits let me know. I think other states will be impacted more than ours, because California already has a state parity law in place.

In California we are blessed that our Medi-Cal benefit structure for mental health is superior to what most private health plans offer. I don't see that changing. People always talk about the "community standard." It's nice that we are able to use our Medi-Cal program as the community standard.

*Renee Becker:* Will certain insurance companies be able to deny benefits; for example, Blue Shield used to say "well, we will only treat your son if he's literally in detox" -- meaning if he doesn't get treatment he's going to die. Are those kinds of issues brought up?

**Answer:** That's the medical necessity part of it. Every plan is going to be able to have their own definition but it's going to be dictated to them how they are going to be able to make those determinations. So it may help a little.

*John Ryan:* Under "covered entities" -- are state of California, county health care plans or managed care plans also covered by this parity legislation?

**Answer:** I would assume so, but I honestly don't know for certain. If they are operating under a Medicaid-managed care agreement with the state the answer is yes.

*John Ryan:* How would parity work?

**Answer:** It would depend on the community standard. If a typical person would see a therapist today and typically be referred for a 30-day visit, that would be the community standard. So, if you had a plan that said "see your therapist today and come back in six

months,” that would not be on parity with the community standard. However, there is no definition on what that “community” is – whether it’s city, county, state or something else.

*Andrew Cavagnaro:* There seems to be some confusion in the California parity act about coverage for people with autism spectrum disorders. Does this act improve on that or make that any clearer?

**Answer:** This act does not talk about diagnoses at all. So I would venture to say it will make it more difficult because it’s not a diagnosis-based statute. California’s is; it lists the diagnoses that must be covered.

*Andrew Cavagnaro:* You said that the critical factor is medical necessity. If a child had autism and a parent was seeking treatment for that child the issue would be does that child meet medical necessity for there to be coverage for applied behavior analysis or whatever other type of treatment?

**Answer:** Yes, and the medical necessity criteria is established by each plan. And that is supposed to be in everyone’s current plan as the EOC, the Evidence Of Coverage.

*Beverly Abbott:* Our understanding is that MediCare is not currently at parity but is going to phase in over three years. Is that right? One of the problems has been coverage and the other is co-pay.

**Answer:** The legislation states that parity will be phased in and full parity achieved in 2014.

### **3. Services for Persons with Mental Illness and Substance Abuse Disorders in Stanislaus County**

*Elizabeth Oakes,* Chief, Adult Services, Stanislaus County, gave the presentation. She discussed the history of co-occurring disorder treatment in the county:

- In 1998, when Ms. Oakes first came to the county, it was decided to move an Alcohol and Other Drug (AOD) treatment program into each of their clinics. At that point there were two stand-alone programs in the same building but not a lot of integration.
- In 2004 Stanislaus County Behavioral Health and Recovery Services (BHRS) decided to change the whole system. It entered into a two-year grant to study implementation of Integrated Dual Diagnosis Training (IDDT). Counties received training from a specific trainer on IDDT.
- In 2006 the county integrated IDDT into its mental health services programs. Everyone was trained and has now entered into the maintenance portion of the implemented IDDT.
- We decided to focus on three things from 2006-2009 – stage-based treatment; formulation, and recovery.

- IDDT uses a team approach and has several components, including stage-wise interventions, recovery dialogue, and motivational interviewing and interventions.
- It was apparent that the IDDT training had not taught staff how to work with people in all stages of recovery. However, the training was very good at engaging people, who would come in and see the doctor and decide they needed treatment. We discovered that there was an entire stage -- persuasion -- that we had skipped. We assumed that people who entered the program were already persuaded, but discovered this was not true.
- We developed a Client Recovery Care Plan. The first thing we talk about with new patients is what are your recovery goals? We came up with eight milestones along the recovery path, including “beginning awareness of problems within oneself,” and moving to “beginning to believe that hope and recovery are possible” and “takes action and steps directed towards recovery.”
- The milestones dovetailed nicely with the training and education we were conducting with staff on stages of treatment. The end goal is recovery and maintenance on all sides.
- People would come in with a couple of things – “I don’t think I need to change” and “I don’t think I could change even if I thought I needed to.” We developed a six-week training program on Motivational Interviewing as a way to help people get “unstuck” in the treatment cycle.
- Motivational Interviewing focuses on expressing empathy, developing discrepancies, avoiding argumentation, rolling with resistance, and instilling self-efficacy and hope. We listen to them and help them see how their goals can be met. It is not a linear process, of course, but Motivational Interviewing proved to be a key to moving the IDDT process along. It’s not just a collection of techniques; it is a way of being.

Ms. Oakes introduced *Mr. Brian Madearos*, a local artist who participated in dual diagnosis treatment. Brian discussed his treatment success and showed some of his artwork. *Ms. Elaine Parkey*, Brian’s case worker, then discussed some of her experiences with Brian and others in the program.

*Stephanie and Bob Madearos*, Brian’s mother and father, talked about the positive changes that occurred for their family when they met some of the National Alliance on Mental Illness (NAMI) representatives, who taught them about the illnesses and medications their family members dealt with, as well as clarifying for them when they could/could not help their family with their problems.

Mrs. Madearos noted that sometimes the most important thing was simply to listen; and above all to never give up hope. Mr. Madearos remarked that Brian’s life greatly

changed for the positive when they got involved with the Stanislaus County treatment program. He cited Ms. Parkey for her contributions. Brian now has an entire social network that assists him, something he never had before.

### **Questions/Answers/Comments with Ms. Oakes**

*Adrienne Cedro-Hament:* First, please provide some feedback on the Council's cultural competency guidelines; and secondly, the Client Recovery Plan forms referenced in the presentation are very impressive -- have they been translated into languages other than English?

**Answer:** All Stanislaus County forms have been translated into Spanish. Modesto Recovery Services also has a multi-culturally diverse staff that speaks Hmong, Cambodian, Laotian, Vietnamese and Spanish.

In terms of the guidelines, some guidelines required modification in order to meet with the IDDT principles. They have learned that, when working with families with predominantly Spanish speakers, it is important to do things in a manner that involve the entire family.

*Shebuah Burke:* The IDDT guidelines sound very similar to the principles used by Alcoholics Anonymous (AA). Do you require attendance at AA or another recovery group, in addition to the one that you are providing? That may be a useful fallback in case of budget and program cuts.

**Answer:** We do encourage involvement in AA or some community support that's identified by the individual. Right now we don't require that because it seemed to us, at first, that it would be seen as a reason for people not to come. In our full AOD program we require abstinence and 12 Steps. The IDDT treatment is not intensive out-patient, it is more educational, and to this point we have not required it, but we do support it.

*George Fry, Jr.:* I was diagnosed as bipolar in 2007 and placed on 11 different psychotropics. I attempted to commit suicide and spent four days in the hospital. Fortunately, a new psychiatrist there helped me and, as of June 2007, I have had a wonderful recovery. As far as the current budget problems, we are all challenged every day of our lives. What doesn't kill me makes me stronger, and I'm getting stronger every day.

*Joseph Mortz:* Does your program have a relationship with the police?

**Answer:** Yes, we have a forensics team that has probation officers on their team. We have crisis intervention training with the sheriff and the police that the county puts on a couple of times a year. Some of our MHSA money is used to embed our emergency service workers for certain periods of the day so they can ride with the police and go out to calls that appear to require some crisis intervention.

#### **4. Services for Persons with Mental Illness and Substance Abuse Disorders in Ventura County**

*Dr. Linda Gertson*, Behavioral Health Manager, Ventura County, gave the presentation.

- She began by noting some of the core competencies for staff working with co-occurring severe mental illness and addiction:
  - Recognition that addiction is a disease.
  - Understanding that there is an interaction between mental illness and disease. Most of our clients have more than one diagnosis. These disorders do not actually co-occur; they interact.
  - Familiarity with the co-morbidity of trauma and addiction. In the Ventura County program over 90 percent of the female clients have a history of chronic, repetitive trauma, beginning in childhood.
  - Training in Motivational Enhancement Techniques.
- She quoted one of their clients, now one of their embedded coaches: “Drugs kept me alive until I was ready to live.”
- Over 40 percent of the VC client population has co-occurring mental illness and substance use disorders.
- In September 2006, because of the success of their program, they were awarded a \$2 million Substance Abuse and Mental Health Services Administration (SAMHSA) grant to extend IDDT services to homeless individuals with co-occurring mental illness and substance use disorders.
- In September 2007 VC received the SAMHSA Science and Service Award, due to the successful implementation of their program and their high fidelity scores as an evidence-based program. They were one of only four programs in the United States to receive this award.
- Dr. Dan Chandler, California Institute for Mental Health (CIMH), the program evaluator for their four-county study, offered to be their program evaluator and continues to study their program and do independent evaluation and data analysis. Dr. Chandler will publish an article in the December Journal of Psychiatric Rehabilitation that will discuss the original four-county study and his conclusions as to why VC was so successful and reached such a high fidelity.
- One thing noted in the article is that the program was implemented with a very motivated and experienced staff. Many demands are placed on staff, and a lot of data is collected.

- Ventura County IDDT Program provides integrated treatment for individuals with mental illness and co-occurring substance abuse. Between September 2005 and September 2009 the IDDT Team conducted over 400 assessments.
- The term “integrated” refers to the philosophy that both disorders (i.e., mental health and substance misuse) must be treated simultaneously. Disorders are treated at the same time, by the same staff, in the same place, in the same way. It is not sequential treatment, nor is it parallel treatment.
- The Program rests on six evidence-based elements:
  1. Accurate and thorough assessment.
  2. Client-centered recovery plans.
  3. Dual diagnosis counseling (individual therapy with licensed clinicians).
  4. Integrated dual diagnosis groups.
  5. Appropriate psychopharmacology.
  6. Case management.
- The integrated assessment takes several hours and is done with the philosophy that the disorders interact. The assessment is client-centered.
- Client-centered integrated recovery plans include:
  - The client’s symptoms of both disorders and functional impairments;
  - The client’s recovery goals as stated in their own words;
  - The client’s strengths (including past accomplishments, motivations and attributes);
  - Barriers to successful recovery;
  - Six-month objectives;
  - Specific interventions agreed to by both the client and the staff; and
  - Community/family support; and discharge criteria and follow-up plans.
- There are individual and group sessions. The first hour is psycho-educational and the second hour is process group.
- There are trauma groups, anger management groups, and life enhancement training.
- Case managers assist clients with access to health care, money management, housing, benefits (such as General Relief, MediCal, SDI, and SSI), employment services, and social support services, including legal and family services.
- We are very familiar with the 12 Steps programs in our community so we can make very specific suggestions of where our clients should start in that process.

- We now have peer support specialists that were trained by Recovery Initiatives California, through MHSA funding. They attend staff meetings, counsel clients, create wellness and recovery action plans, facilitate medication support groups, and provide other services.
- We also now have a psychology internship program and are taking in practicum students and interns. We are trying to train the next generation of dual diagnosis experts.
- Many of our clients are self-referred; others come from private, non-profit agencies that serve the homeless and other populations.
- All our forms are in Spanish and English and we have mandatory cultural competence training for all staff in VC Behavioral Health. All staff must attend training at least once a year.
- We see that we have to bring in more people who are monolingual Spanish speakers, so we can more accurately reflect our county demographics.
- There are four stages of treatment:
  1. Engagement;
  2. Persuasion;
  3. Active Treatment; and
  4. Relapse Prevention.
- The goal of treatment is to assist clients with movement along the continuum of stages. 77 percent of our clients, at the 12<sup>th</sup> month mark, have moved along at least one stage in the continuum stages of treatment.
- As you know, addiction is a chronic, relapsing disease; and mental illness can be as well. Our attitude is “no wrong door, no closed door.” We accept clients from multiple referral sites and we never dismiss a client just because they relapsed. We see relapse as part of the disease and part of the learning process.
- The only time we will temporarily suspend a client from our program is if they threatened another client (which has only happened twice) or if they threaten a staff member (which has only happened once). When we feel they have learned enough to come back without being threatening then they go right back into the program.
- Stages of change include:
  1. Pre-contemplation;
  2. Contemplation;
  3. Preparation;

4. Action; and
5. Maintenance.

- As with stages of treatment, the goal is to assist clients in movement along the continuum of the stages of change. Sixty percent of our clients have jumped at least one stage of change within 12 months.
- Eighty percent of our clients avoided hospitalizations during their time in the IDDT program and 80 percent also avoided incarceration. These are both highly significant statistical figures. In addition, 81 percent were compliant with their medication regimen.
- Only one percent of clients were never completely clean and sober for a period of at least 30 continuous days during the first six months of their treatment.
- Client self-rating of their health from “poor” when entering the program to “good” six months into the program are also statistically significant. Again, these are homeless clients. Everything went down – depression, anxiety, hallucinations, violent behavior -- in a statistically significant way.
- Cognition did not go down, which shows us that the drugs most of these clients use have a profound and long-lasting effect on the brain, particularly the pre-frontal cortex, which is what we use for so-called “executive functioning.” The very part of the brain that we use for judgment remains off-line, even after individuals get clean and sober. This is especially true with methamphetamine. This is extremely important because it means that the very part of the brain that we want to engage with when doing therapy is off-line.
- In early sobriety people cannot handle complex issues. Thus, staff is trained to do psychotherapy in gradations.
- The data is also showing that individuals who have experienced early, chronic trauma have long-term deficits in pre-frontal cortex strategies.
- Our data is duplicating what we are seeing internationally. This data needs to dictate the type of treatment that we do with clients. We cannot move them along faster than their brain can handle.
- A significant body of research indicates a very high co-morbidity between substance use disorders and trauma.
- Every six months we administer the Beck Depression, Anxiety, and Hopelessness Scales and there is a strong correlation between clients who experienced trauma and lower scores along the three scales.

- As clients maintain sobriety they start working on their trauma issues, which can exacerbate their symptoms. As clients start to deal with their trauma issues, which they need to do, it can drive them back into their addictive processes, and staff need to be very aware of where their clients are in terms of their recovery process.
- In most recovery programs the emphasis is on group therapy. Our data is showing that, in terms of success of treatment, the greatest proportion of the variance is with individuals who also receive individual therapy. From an economic standpoint, there is more “bang for the buck” with group therapy. However, individual therapy may be equally or more important.
- People sometimes start remembering their trauma when they stop using drugs and alcohol, which can drive them back into using. Many times people will have fragmented memories of their childhood if they had severe trauma. They may start experiencing so-called “flashbulb memories” of their trauma, which can be extremely powerful and traumatizing. Special techniques need to be learned and applied to treat these situations. This is another reason why individual therapy may be so important.
- We think the Ventura County IDDT Program works (from our perspective) for the following reasons:
  - It is a reflection of the complete and continuous support of the VC Behavioral Health Administration;
  - The management and staff are experienced in dual diagnosis assessment and treatment and are fully committed to the success of the program;
  - There is immediate implementation of IDDT (during training rather than waiting for completion of training);
  - A willingness of the staff to change and adapt;
  - Ongoing clinical supervision by an experienced dual diagnosis clinician;
  - Staff participation in the development of program forms, program development and outcome measures;
  - Advertisement of the program in behavioral health newsletters and other outlets;
  - Development of staff cohesiveness;
  - Groups composed of individuals in various stages of Change and Treatment;
  - Inclusion of PTSD/trauma, anger management and LET groups;
  - Flexibility of staff schedules (e.g. evening groups);
  - Groups conducted onsite and offsite;
  - Encouragement of client development of Dual Recovery Anonymous groups;
  - Inclusion of outcome measures;
  - Feedback to staff of client outcomes; and
  - Use of outcome measures for continuous program improvement.

## **Questions/Answers and Discussion with Dr. Gertson**

*Doreen Cease:* Is there any program like this in Los Angeles County? Can a person from LA County get into one of your programs?

**Answer:** LA was part of the original program but they contract out a lot of their work. Ventura County (VC) contracts out much less. There is a real cohesiveness in VC that helps us. I don't think an LA County person would be able to get into our program. Thank God for MHSA -- their monies saved our county, because of the present economy.

*Adrienne Cedro-Hament:* The cultural competency guidelines – please provide your feedback, and did you find it helpful?

**Answer:** I did read it and found it helpful. That's why I included some of the data on our ethnicity. We know we need to do more outreach into the other segments of our demographics. I look at the data from our operational reports and I know we want to diversify further.

*Beverly Abbott:* You also included data about gender. It's great to see the data on trauma highlighted, which generally doesn't get much attention, even though it's huge in terms of treatment.

The Planning Council has previously heard testimony about concerns that evidence-based practices are sometimes too "right" and if you depart from them the people teaching and promoting the practices feel like it's not legitimate. It sounds like you've been able to depart from that and what you said doesn't sound consistent with complaints we've heard. Did you get any significant push-back – we've heard that if you don't do it exactly as they tell you to then they dis-enroll you. I know that SAMHSA has declared your program to be an evidence-based practice. Do you accept that?

**Answer:** Let me preface this by saying that a lot of things called "evidence-based practice" are really not evidence-based. That term is so loosely used that I find it almost offensive at times. We do accept the SAMHSA definition. What SAMHSA did with the IDDT is randomized, controlled studies, which is the only way you can really say that it's evidence-based. Also, they have some studies that have shown that IDDT is definitely better compared to other studies, although other studies have shown it wasn't definitively based.

One of the reasons Dr. Chandler initially became interested in doing data with us was the whole evidence-based thing. When he heard we were doing outcomes he said "I'm in." He has had several SAMHSA grants and he wants to contribute to the literature.

We liked the SAMHSA scale because they said "you have to do an integrated assessment." And I asked Dr. Chandler if we had to do a certain form and he said "no." So we developed our own form and developed the outcome measures. And we're trying to use our outcome measures to learn.

Our next step, we're hoping, is for VC to use its outcome measures to go before our internal review board and ask the hospital for permission, given the outcome measures as a pilot study, to do a randomized control.

*Carmen Lee:* The 34 points that you mentioned initially, that you had to keep data on, were they all covered in your slides?

**Answer:** The 34 points are the components of the IDDT fidelity scale. That is what SAMHSA calls the evidence-based program. As soon as I saw the scale I intuitively said “that’s how you do dual diagnosis.” So it met my “gut” test.

*George Fry, Jr.:* How many threshold languages do you have in your county? Is your billing also bilingual?

**Answer:** The predominant languages are English and Spanish. There is also a fairly large Filipino population. Most of our clients are either indigent or Medi-Cal, so they actually don’t get a bill. If they do, we have individuals who speak Spanish and Tagalog who can explain the bill to them.

*Monica Wilson:* I wanted a little more clarification on the outreach process. Did you originally, when you did recruitment, look at the various communities and understand why the data is so low for African-American and Asian populations?

**Answer:** Initially we took clients already enrolled in our program, and that’s the original demographics. It’s really as the data comes in that we’re now seeing where the deficits are.

## **5. Update on Cultural Competence Issues**

*Autumn Valerio,* Office of Multicultural Services, Department of Mental Health, provided the update. She discussed the Latino Access Study (LAS):

- In California the Statewide Quality Improvement Council (SQIC) and the Cultural Competence Advisory Committee made a recommendation to DMH to include an LAS as part of the quality improvement plans required in the Mental Health Plan (MHP) contracts for Fiscal Year (FY) 2002-03.
- According to the Department of Finance, California’s Latino population is expected to double between 2000 and 2050 and will then represent approximately 52 percent of the population of the state.
- DMH agree and issued a letter to counties requiring the county MHPs to conduct the LAS.
- All county MHPs with Medi-Cal eligible populations of 10,000 or more and/or counties with Spanish identified as a threshold language were required to complete the LAS.
- The SQIC recommendations focused on two areas for examination:
  - Initial access studies could include outreach efforts to increase access, stigma, and/or healthcare/mental health partnerships;

- Secondary access studies could include retention issues, the effects of extended clinic hours, and/or barriers for Latinos with Limited English Proficiency (LEP).
- Thirty-seven county MHPs submitted a copy of their LAS to DMH and the focus and methodology of studies varied greatly from county to county.
- Challenges of the LAS included limited direction and guidance on how to conduct the study; no direction or uniformity as to what was expected of counties in conducting the plan was forthcoming. In addition, the LAS had no funding. Many limitations on available data were discovered and few counties were able to substantiate a significant increase in Latino access as a direct result of the LAS.
- Many of the studies were able to identify some of the barriers to access, including:
  - Limited staff resources to make services more widely available;
  - General lack of information or understanding of mental illness/mental health services;
  - Stigma;
  - Language barriers/lack of bilingual staff/lack of trained interpreters;
  - Transportation barriers;
  - Restricted hours of service;
  - Fear related to immigration/residency status.
- These findings are consistent with extensive national research regarding Latino access barriers.
- The intent of the LAS was to start looking for solutions to some of these problems. Some counties were able to identify solutions, but this is an ongoing challenge.
- For example, San Mateo County LAS included:
  - Penetration rates by location and language;
  - An analysis of the correlation of penetration rates and other indicators of access with available data on the ethnic and language distribution of staff;
  - A review of all policies, procedures, and practices affecting Latino access at primary points of access;
  - An analysis of available summary data on satisfaction and complaints concerning Latino consumers;
  - An analysis of MHP staff satisfaction surveys;
  - Interviews and focus groups with Latinos representing mental health consumers and family members, community members not involved with the mental health system, key contacts in the Latino community, and local Latino mental health clinicians.

- Sacramento County LAS solutions included:
  - Initiated an 18-month study to examine and identify barriers to community-based mental health services for the Latino community;
  - A multi-tier approach, including a large county-wide study and individual LAS for each agency or program;
  - A system-wide committee -- the LAS Focus Group -- convened to develop the countywide study;
  - The LAS Focus Group committee conducted five county-wide focus groups representing current and former clients, family members, community leaders, and Healthy Start Coordinators;
  - Focus group questions were developed in both English and Spanish, and the goal was to identify barriers for the Latino community in the county and design strategies for removing those barriers;
  - In response to the focus group's findings, Sacramento County planned a second phase of the LAS to develop strategies and interventions to address the barriers identified.
  
- Los Angeles (LA) County conducted a multi-phased LAS, which included:
  - An extensive literature review regarding available research on Latino access to mental health services;
  - Assessment of quality of data collection and procedures which impact data collection;
  - Convening focus groups with mental health consumers and clinicians;
  - Focused on addressing one of the most critical barriers identified – language access.
  
- LA County developed a pilot study to evaluate Interpreter Training outcomes with a goal to increase cultural competence of the providers when working with monolingual or LEP populations. Pilot study data indicated a significant improvement of knowledge from the pre-instruction time point to the post-instruction time point.
  
- LA County DMH continues to evaluate the Interpreter Training Program and has dedicated resources from the MHSA Workforce Education and Training component to increase program capacity.
  
- Some small counties were able to improve access for Latino consumers by offering flexible clinic hours, including services via a “walk-in” basis and via telephone.
  
- Overall, promising strategies included:

- Engagement: engaging local community leaders and community members in the development of local anti-stigma campaigns.
  - Organizational Structure: Latino access was increased by offering flexible service hours and “walk-in” appointments.
  - Workforce: identified need for increasing the number of bilingual staff to address the needs of large Spanish-speaking communities in counties.
  - Training: funding Interpreter Training Programs increases competency and is a beneficial investment.
  - Program: practicing “enhanced case management” as an outreach strategy between first contact and the initial assessment and building “relationship-based connections” grew Latino access.
  - Welcoming Environment: providing comfortable, culturally appropriate surroundings (i.e. use of Latino art, Spanish language videos, brochures, posters, etc.).
- One of the biggest projects DMH has underway is the California Reducing Disparities Project. The first of three Requests For Proposal (RFP) have been released and the Intent To Award for the strategic planning workgroups portion.
  - Contracts were awarded to five populations who will produce population reports that will contribute to a comprehensive strategic plan to reduce disparities for multicultural communities.
  - The awardees are:
    - UC Davis for Reducing Health Disparities (Latino population);
    - African-American Health Institute of San Bernardino County (African-American population);
    - The Native American Health Center (Native American population);
    - The Equality California Institute (LGBTQ population); and
    - Pacific Clinics (Asian and Pacific Islander population).
  - DMH is in the process of developing the contracts and a kickoff meeting will be held on October 20<sup>th</sup> for the five contractors and DMH staff to meet and talk about the vision of the project.
  - It is hoped that these contracts will be executed by December.
  - Two other RFPs are being developed and will be released soon:
    1. To fund a multi-cultural coalition; and

2. To fund a single facilitator/writer who will be responsible for working with the coalition and each of the five strategic planning workgroups to create and develop the one comprehensive strategic plan for the state of California to reduce disparities.
- The cultural competency plan requirements are in the final phase of the approval process and we hope to have final approval and requirements released within the next two weeks.
  - DMH is also in the process of negotiating with the California Mental Health Director's Association and small county directors to produce an abridged version of the cultural competency plan requirements for very small counties. This is still being negotiated.
  - Also, in 2008 DMH contracted with the Inter-Tribal Council of California (ITCC), with MHSA funds, to improve the inclusion, engagement and collaboration between Native American communities and county mental health departments. As part of those objectives, ITCC developed the Native American Resource Directory to provide county mental health departments with information on California's Indian tribe tribal programs and tribal organizations, by county, in an effort to establish and foster ongoing partnerships with county mental health providers and to improve services for tribal communities. The resource directory is available for download on the Office of Multicultural Services website.
  - You can also now sign up on the DMH website and receive automatic e-mail updates when DMH updates the website with new information.
  - New fact sheets are also posted on the website – on language access; on what the Office of Multicultural Services does for DMH; and on community engagement. DMH is also working on facts sheets regarding disparities data; ethnic services managers; what is cultural competency; and what is the Cultural Competency Advisory Committee.
  - Two other contracts -- for translation services and for cultural competency consultants -- are in the routing and approval stages and will be executed shortly.

### **Questions/Answers and Discussion with Ms. Valerio**

*Patrick Henning:* Is what you found in the LAS study what you wanted to get out of it? There seemed to be a lack of uniformity in the data and much of the information presented seems to already be known.

**Answer:** I agree that much of the information in the study is not new. The studies were conducted in 2002-03. We are hopeful that some of our newer projects will help us find the next steps.

*Luis Garcia:* I'm surprised that the insurance issue is not included in the information. On a daily basis I deal with people asking for services who don't have insurance. Also, we have enough data; what we need is an action plan so we can begin to move forward.

**Answer:** I fully agree with that. The purpose of the California Reducing Disparities Project and developing a strategic plan is to finally get to that action plan and begin to implement solutions.

*Adrienne Cedro-Hament:* Our Cultural Competency Committee would like to discuss the DMH Strategic Plan in January. We requested a written report from Office of Multicultural Services (OMS) that would include two points: first, a detailed annotation of the aspects of the plan where cultural competency is evident; and second, we requested DMH's cultural competency plan. The last information we got was that it would be embedded in the strategic plan. It would be very helpful to have a response from DMH that tells us where the cultural competency portion is in the strategic plan. We need to have that by December so we can process it.

**Answer:** I will take your requests back to Ms Guerrero (Chief of OMS).

*Joe Mortz:* There has been discussion -- sometimes very aggressively -- about receiving this cultural competency plan since 2001. The African --American community is identified as being over-served by 19 percent. The truth is that the African-American community is not appropriately served at all, if you look at the Medi-Cal data.

A reasonable look at the access data the state has is possible and shouldn't take nine years. The barrier, regardless of the motivation, is so significant that a strong statement needs to be made. We have not had a professional report -- there is a serious competency issue and the data needs to be identified. In my opinion, this type of data reporting is unacceptable.

*John Ryan:* It seems that the data presented could be applied to any other ethnic group in the state. It seems that the unmet need is going up significantly in every county across all target groups.

**Answer:** I agree, there is a large unmet need. There is a crisis with fiscal and staff resources, and counties are struggling to keep employees and provide services. I think the question would be is there still a disparity, despite these current realities, in access to and quality of care for particular population groups.

*John Ryan:* The counties have been required to do a cultural competency plan since 1998 and DMH hasn't done one yet. My sense is that no one really knows what the components of a good cultural competency plan are and what the state basically did was require the counties to go through the learning curve for the state. The counties made their best effort and came up with plans and the state reviewed them and chose the portions they thought were good ideas. It would still be nice if the state took a leadership position and demonstrated how to do it, rather than nitpicking somebody else who is trying to do it.

**Answer:** I take your comments and will report them back.

*Beverly Abbott:* The Policy and Systems Development Committee spent a year hearing from counties about how they were doing and counties reported efforts to do a lot of outreach but it seems, from the data that we've been seeing, that there hasn't been a lot of progress. We know that counties are being undermined financially while they try to do these outreach efforts.

There are different issues. One, we have been promised a cultural competency plan from DMH and I think that patience has run out for people. Two, data comes out and we need to really understand what the problems are and improve that data collection, but we already have enough data to show that there are disparities. So I guess the question is what are DMH and the Council going to do to mitigate that?

Perhaps the Cultural Competency Committee could pull in some people and do a day's workshop on this. We never seem to have time to take action on this. For example, we'd really like to hear from the people who got the grants for the outreach initiatives. Maybe we need to build our agenda as a Council in addition to as a committee.

*Chair Mueller* suggested that this needs more discussion time within the Committee and if a day-long workshop makes sense we will talk about that.

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

*Patrick Henning* provided the report.

- The Commission is looking for a new Executive Director. Interviews are underway and hopefully a determination will be made soon.
- Three Commissioners have resigned, all for different reasons – Darlene Prettyman, Bill Kolender, and Tom Greene.
- Over 745 MHSAs housing units, out of Prop 63, have been provided for.
- Over \$400 million of Prop 63 funds have been spent for financial support in prevention and early intervention. Forty-five plans have been approved overall.
- The OAC has also finalized a contract to survey and collect data for a comprehensive evaluation of the Proposition and where we are, as we approach the five-year anniversary. We haven't seen the progress that we would have liked but we've seen little bits and pieces of change that shows what the system could become. The survey will hopefully show us the positive steps we've taken and the mis-steps, so we can correct them. We determined that we needed to provide additional oversight and accountability and it would be better for an outside group to help us see where we're at now.

## **7. Adjournment**

*Chair Mueller* adjourned the meeting at 5:23 p.m.

## **Thursday, October 15, 2009**

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

*Chair Mueller* called the meeting to order at 8:38 a.m. Planning Council members and guests in the audience introduced themselves.

### **2. Committee Action Items**

Children and Youth Subcommittee. No action items.

Transition Age Youth. No action items.

Adult Subcommittee. *Barbara Mitchell* commented that their group has been looking at issues regarding state hospitals and the monitoring of the consent decree. They have an action item seeking approval for a letter to be sent to DMH from the Planning Council, requesting that DMH develop a plan to include consumer and family members in the continuous quality improvement plan at the state hospitals.

The subcommittee is concerned about the amount of consumer and family member input into the processes that are being developed, especially regarding the monitoring of seclusion and restraint.

**Motion:** The Council approved the motion to send the letter.

Older Adult Subcommittee. Stephanie Thal reported three action items:

1. Federal statutes require states to develop state plans for the use of community mental health service block grant funds for adults with serious mental illnesses and children and youth with serious emotional disturbances. Older adults are not identified as a separate target population; however, they have unique and complex needs different from those of adults and should therefore have a separate state plan.

The subcommittee passed a motion to amend federal statutes to add older adults with serious mental illness as an additional target population within the SAMHSA block grant and is now in the process of determining the appropriate person to contact regarding how that should be done.

*Ms. Cedro-Hament* further clarified that their motion is to send the letter to the appropriate SAMHSA representative and see where it goes from there.

**Motion:** The Council approved the motion to send the letter to the appropriate SAMHSA representative (Abstained – Bellotti, Stout, Marquez, Cabrera).

2. The Subcommittee discussed the possibility of writing a letter to the Governor, with copies to Speaker of the House Karen Bass and Senate Pro Tem Darrell Steinberg, expressing the Council's concerns over the budget cuts and the impact it's going to have. It was the committee's feeling that, although the letter will have no direct impact on the budget, it was their sense that this may involve many more elderly becoming institutionalized rather than being able to be served within their community.
3. An additional motion was discussed -- to send the same letter, or a similar one, to the potential gubernatorial candidates for the next election.

**Motion:** The Council approved the two motions to send letters to the Governor, Speaker of the House, Senate Pro Tem, and potential gubernatorial candidates (Abstained – Bellotti, Stout, Marquez, Cabrera, Alves).

Cultural Competence Committee. No action items.

Policy and System Development Committee. *Ms. Abbott* referenced a series of recommendations that are listed on the back of the Policy and System Development End of Year Summary. For the last year the Council has been hearing from counties on what is happening with the implementation of MHSA and the budget situation. The bottom line is that there are some incredible and innovative programs being implemented. People are doing things differently and better because of the MHSA.

On the down side, the budget cuts have significantly undermined the basic infrastructure of many counties.

The Committee is specifically requesting action today on the housing recommendations listed on the back of the End of Year Summary. They request that the full Council adopt the recommendations and get them moved into the process. Also, there may be a revision of the overall summary that will subsequently be disseminated to the Council. The Committee will continue to monitor the implementation of the MHSA and the effect of budget cuts on counties.

**Motion:** The Council approved adoption of the housing recommendations (Abstained – Henning).

Human Resources Committee. There are no action items. *Ms. Mueller* stated that the committee will be conducting a survey to ascertain the status of nurse practitioner programs in California – where they are located, how many potential graduates, etc.

*Brian Keefer* noted that the committee is attempting to highlight how the traditionally under-served counties are utilizing MHSA training funds.

The Committee has been delegated the responsibility of looking at implementation issues for workforce education and training. Currently, almost all of the local plans are in and accounts for about \$190 million of the \$200 million available.

Most of the contracts are executed and in play. Thus, workforce education and training has been implemented and we will begin to look at process benchmark evaluations in the next year.

One of the highlights will be that we will have local and statewide financial incentive programs running for the behavioral health care workforce in California, something that did not exist 10 years ago, when the Council was formed. In the long term, we want to have better leverage with the federal government in being able to determine that mental health workforce individuals in California and other states do have a significant population in order to apply for financial incentives federally and to affect the flow of federal dollars.

Quality improvement Committee. There are no action items. *Gail Nickerson* reported that there is an area that California is not in compliance with the SAMHSA block grant – peer review of counties – and the Committee is planning to involve itself in that. In addition, a public hearing was conducted at their most recent meeting. If others are interested, those comments will be available in the meeting minutes.

*Lin Benjamin* asked for clarification about the next steps after a decision has been made to accept the performance indicators. Also, how does that relate to what is occurring in the OAC’s evaluation committee? *Karen Hart* responded that the OAC is well aware of the indicators and will be looking at them in a collaborative way. However, the committee is not yet at the stage of selecting indicators, although it makes sense that the Council and OAC will dovetail their ideas. *Daphne Shaw* clarified that the Council’s mandate is to select the indicators; what happens after that, in terms of implementation, is beyond their scope.

### **3. Approval of the June 2009 Meeting Minutes**

*Renee Becker* asked that page 3 of the Minutes, referencing the HR Committee, where it says “*Becker announced that she will continue to advocate to change the language from consumer versus client . . .*” be changed to “. . . *continue to advocate to include parent caregiver of minor children next to consumer and family members whenever parents of minor children are included or invited.*”

Staff stated that this statement was in the Human Resource Committee minutes, and not the Planning Council Minutes. HRC staff will change this for Becker.

**Motion:** The Planning Council Minutes of the June 2009 Meeting were approved as written.

### **4. Approval of the Executive Committee Report**

*Chair Mueller* provided a synopsis of the Executive Committee Report:

- The Council’s budget for next year and the expenditures for the current year were reviewed and the budget was approved as presented in the packet.

- There was a DMH report from Sophie Cabrera.
- A paper was submitted regarding consensus-based decision making, which prompted much discussion. The conclusion was that an entirely consensus-based decision making process for all policy issues regarding MHSA would make things extremely slow and perhaps introduce more problems than would be resolved. The recommendation was to not adopt the process.
- The OAC Legal Counsel advised that their status as ex officio members of the Planning Council gave them a vote on the Planning Council. This has been referred to the Attorney General for interpretation and further clarification.
- Changes in the language of the 2010 Memorandum of Understanding update of the stakeholder public comment process were approved.
- A couple of approaches for the CMHS block grant peer review were discussed and the Committee referred the approaches to the Quality Improvement Committee for further consideration.
- The nominating committee that will propose the chair-elect for 2010 was approved.

*John Ryan* discussed the summary of responses for “vital signs.” He noted that over a billion dollars is being spent in California on mental health but do we have a running track record of whether things are getting better or worse? It seems we lack a systematic statement on what the need is for mental health services in California and how much of that need we are addressing. We need a clear, simple statement that says “when people come to get help, they get help.” Are we helping them or not?

This “thumbnail indicator” should be something that we have a sense of, on an ongoing basis, and it seems to me that we don’t have that; rather, we have various “snapshots in time.” It’s not clear what the vital signs are. There must be a way that we can get to the essence of it and track that.

*Beverly Abbott* remarked that the Planning Council could pull -- from the indicators set, from the disparities data, from client satisfaction -- these vital signs. However, it can get hugely complex in such a large state and would be difficult to summarize.

*Daphne Shaw* commented that one thing the Planning Council may need to do, in collaboration with the OAC, is to figure out how the various stakeholders can feel included in this process in a meaningful way.

*Joe Mortz* requested that the Council not approve the Memorandum of Understanding. He stated that it is important that we understand the public’s desire to have a lot of input but this is not the path to achieving that. When Prop 63 was passed the idea of joint

meetings of the Council and the OAC were too complex; the OAC needed time to organize itself. Now, through the MOU, we are looking at creating sets of partnership silos, which will burden the process. I'd like to see fewer silos and more opportunity for public participation.

Perhaps having the OAC and the Council go to the Attorney General may settle the issue very bluntly, by stating that the law says we are supposed to be one silo only. We are not only an advisory committee, we also have oversight issues. I think that our laws and mandates are much more definitive and we should be asserting our status not as partners but as authorities.

**Motion:** The Executive Committee Report was approved as submitted (Mr. Mortz voted "Nay").

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

James L. McGhee, CALM Board President, reported that they held their annual board meeting and conference in June in San Jose. There were 179 attendees and numerous workshops were held. The workshop evaluations stated that people were very pleased with the information received at the workshops.

Annual elections were also held and there are now seven new board members.

One of their objectives was infrastructure development. To that end, a board handbook was put together that includes a Board of Directory, an introductory history of the Board, and other pertinent information. In addition, a board self-evaluation was introduced.

The strategic plan for 2010-11 was also passed by the Board.

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

Patricia Ryan, Executive Director, CMHDA, provided the report. She summarized some of the policy issues they are dealing with:

- Cash flow to counties. Separate and aside from the budget, getting cash to counties so they can pay for the programs they are required and mandated to provide, and want to provide, continues to be a struggle. In the year thus far counties have not received state General Fund payments for Medi-Cal or for the AB 3632 program. Both programs were cut in the budget but the funds that were approved have not yet been sent to the counties. Counties are paying for services and still waiting for reimbursement.

- Proposition 1A requires the state to either suspend the mandate or to fully pay the mandate in the year that it's owed. The legislature and the administration chose to violate Prop 1A and not pay counties fully for the program. Going back to FY 06-07, the state owes counties \$160 million; only \$52 million was included in the budget to pay counties.
- In addition, the state still owes counties over \$400 million for AB 3632 for unreimbursed claims in years previous to Prop 1A. That means that the missing money is now coming out of other services, which includes monies for indigent adults and others. It really needs to come out of realignment or other flexible funding but, as we all know, that's been greatly reduced because of the economy.
- The combination of all these things paints a bleak picture at county mental health.
- CMHDA is planning on working with the Council, the OAC and everyone else to identify some of the new and creative programs that have been funded because of the MHSA.
- The workforce education and training, at both local and regional areas, are being funded and counties are developing a new, creative and talented workforce as a result of that.
- IMD exclusions state that Medi-Cal cannot be billed for any services that are received by people in those medical ancillary programs. However, providers have billed the federal government for medical services and the state has been found to be out of compliance and has had to pay some of that back. There is no clarity on this issue. People are going into long-term psychiatric hospitals or institutions for mental disease and there is no way to pay for their medical or psychiatric ancillaries. We talked to DMH and MHS about this again recently but no one yet knows how to handle the situation.
- We are very committed to making the statewide Prevention and Early Intervention projects operational as quickly as possible.
- The tax relief from realignment is down and starting next year -- and for several years after that -- we are going to have a major downturn in MHSA receipts. Counties are in the process of projecting into the future their likely revenues and trying to build programs, to the best of their current knowledge, that are sustainable for as long as possible.
- The budget had a \$1.2 billion unallocated reduction in the Corrections budget. Prior to that being adopted, Corrections had been bringing parolees to counties for release, but there is currently no collaborative process in place for transitioning these people back into the community. We are working on that process as well.

*George Fry, Jr.* commented that he went to a recent CMHDA meeting in Napa, where he was told that he couldn't sit in on the meeting. He hopes that CMHDA will understand that it is a public meeting and he just wanted to hear what was going on. *Ms. Ryan* responded that CMHDA is a non-profit advocacy organization and that particular meeting was their governing board meeting; it wasn't a public meeting. *Mark Refowitz* added that this was a governing board meeting for its members. CMHDA is not a governmental entity, it is a membership organization, and there are some meetings where they need to talk among themselves.

## **7. Public Comment**

*George Fry, Jr.:* I'm here to talk about the National Empowerment Center in Lawrence, Massachusetts. Every year an Alternatives Conference is put on and next year it will be coming back to California. (A handout was distributed as Mr. Fry spoke.)

Dr. Dan Fisher, the Executive Director of the National Empowerment Center, sent an e-mail stating that they were looking for sites and I started working on a program for the conference to come to Angels Camp, California. I am requesting that all of you take the time to send an e-mail or write to Dr. Fisher, requesting that the conference be held in a rural area for a change.

My goal is to have 90 organizations that will help finance this, so clients will not have to pay for anything to attend the conference.

I am also holding a golf tournament. Please take a look at that information also.

*Ms. Judy Gomez:* A Santa Cruz County special ed and vocational teacher, she stated that she attended the Alternatives Conference in Portland two years ago and it was a life-changing event for her. MHSA should support people in the community going to a conference like that so we can learn from each other. Funds need to be made available to people for this life-changing event.

## **8. Co-occurring Disorders: Perspective from the Mental Health Oversight and Accountability Commission (OAC)**

Dr. David Pating, MHSOAC, gave the presentation. Some highlights:

- The Mental Health Services Act (MHSA), also known as Proposition 63, passed in California in 2004 with 54% of the vote. It created the OAC to approve certain county mental health programs and expenditures.
- The MHSA imposes an additional 1% tax on taxpayers' taxable personal income above \$1 million, which accounts for about 20% of the funds coming into the mental health system in California.
- The MHSA has five priority areas: client and family-centered treatment; cultural and linguistic competency services; recovery and wellness services; community partnerships; and integrated service experience. Later, a sixth goal was added – co-occurring disorders competency.

- The OAC Chair is Andrew Poat; and the Vice-Chair is Larry Poaster. There are five Committees – Services, Finance, Client and Family, Cultural and Linguistic Competency, and Evaluation.
- OAC has five priorities for 2009:
  1. Get all the monies out as quickly as possible.
  2. Better define what “transformation” means.
  3. Develop an evaluation practice.
  4. Clarify the stigma discrimination efforts.
  5. Determine how to implement ABxxx.
- OAC is currently working on three things: the criteria for Prudent Reserves; the dissemination of between \$120-160 million in statewide Prevention and Early Intervention funds; and development of something to address stigma discrimination.
- It is also developing a complaint process at the county and state level.
- The OAC Co-Occurring Disorders Workgroup Report suggests providing two levels of integration: first, integration of services; and second, integration of policy efforts.
- If we want to make mental health work, we need to keep people out of the hospital, out of jail, out of foster care and off the street. That is where people with co-occurring disorders end up when we are not addressing their needs.
- The tenets for the Workgroup include:
  - Effective services for people living with serious mental illnesses requires a “whatever it takes” focus.
  - At the level of services delivery, the services must be integrated.
  - “Whatever it takes” means flexibility of funding.
  - Integrated services means “no wrong door” service care and a coordinated team of caregivers.
- The Report’s key findings include:
  - Co-occurring disorders (COD) are pervasive. About 50% of people with mental illness also have substance abuse disorders. There is a lot of overlap between the two.

- Co-occurring disorders are disabling.
- Individuals with co-occurring mental illness and substance abuse are among California's most under-served.
- Insufficient support for integrated COD programs leads to a paucity of treatment facilities and properly trained clinicians.
- Four public issues surround mental health:
  1. We are in a hospital crisis in California. There is a steady decline of psychiatric hospital beds in the state. New hospitals are too expensive to build but we need to figure out a way to fill this gap.
  2. Jails are overcrowded. In some counties 50% of incarcerations are substance abuse related.
  3. About 70% of foster care children suffer from mental health and/or substance abuse disorders.
  4. It costs \$61,000 each in California to deal with homeless people who suffer from mental health and/or substance abuse disorders.
- The Co-occurring Joint Action Council (COJAC) developed a statewide plan that looked at funding sources. There is money out there for co-occurring disorders.
- Sixteen counties are up and running with training in COD.
- Peer and family models are particularly effective in dealing with CODs.
- We know supportive housing works, as does Full Service Partnerships.
- How do we get where we want to go? One way is to support the co-occurring state plan of COJAC, especially with workforce training.
- Transformation requires changing the culture of care in our system so that it is collaborative and forms partnerships.
- Ten transformative goals for the MHSA were created:
  1. Create a comprehensive culturally competent integrated system.
  2. Establish system partnerships.
  3. Encourage DMH and Alcohol and Drug Programs (ADP) collaboration.
  4. Provide ample training and technical assistance.
  5. Close the gaps in the continuum of care.
  6. Expand peer-based wellness and recovery services.

7. Support families to enhance recovery.
  8. Effectively recognize and treat trauma.
  9. Use outcomes to ensure progress.
  10. Provide incentives to promote transformation.
- Where we are now, during this recession:
    - MHSAs funds cannot be used to supplant existing services, so what some counties are doing is transitioning employees from, for example, a declining ADP program and putting that person into the county mental health clinic -- thus preventing the loss of an important part of their workforce.
    - Some counties are moving from funding programs to determining where they need to target services.
    - A COJAC screening tool is being piloted in San Francisco, Los Angeles and other counties. It is a very basic diagnosis that can be used to determine whether a person should be entering the mental health system.
    - The Administrative Office of Courts decided that most of their mental health needs were co-occurring and asked OAC what could be done. Responses included using a screening method to do early intercepts; also, peer counselors in the courtroom could be used to tell judges how to refer people to the community, if the judge feels they don't really want to put them in jail.

*Andrew Cavagnaro:* What are the best estimates of the number of people in California that have co-occurring disorders?

**Answer:** The rate of mental health disorders is probably between 18-20% overlap -- but it's hard to answer because what I see in the private sector versus public sector versus what I'll see at Kaiser . . .

## **9. Report from the Department of Mental Health**

Dr. Stephen W. Mayberg, DMH Director, provided the report. Some of the issues:

- DMH is looking at applications for Planning Council vacancies and reappointments. We will have the appointments by January 2010.
- The impact of the state furloughs is extensive and creates a lot of stressors outside work. The amount of work time lost through furloughs is seven weeks per year; add the hiring freeze to that and we have about 200 less people at work out of 500 people total. Between frozen positions, unfilled positions, layoffs and the 15% furlough, it adds up. Essentially, it's about a 40 percent reduction, so you just can't complete the same amount of work.

- We have been discussing the things that we can no longer do in a timely fashion and how to handle that. We're just slower now.
- A lot of our time is spent dealing with the budget situation. We're billions of dollars off already from the budget that was passed ten weeks ago. The revenues haven't held up and some of the proposed budget cuts were enjoined by the courts and can't be made. California hasn't recovered yet and we won't see income gains for probably 18 months.
- As of the end of this month DMH will be current; i.e., all monies owed will have been disbursed. The turnaround time now for Medi-Cal is 60 days or less and will soon be 30 days. So we are moving forward with that. Counties really need the money. Moving cash is a very important issue for us.
- We have suspended several reports that previously were required, as we simply don't have the manpower to review them.
- Regarding the data on the Latino Access Study and from elsewhere, we are aware of some of the flaws but it is not our top priority. While data is critical, having cash to the counties is just as critical.
- We also have the dilemma of the 15% furlough at the state hospitals. Unfortunately, we can't simply close the hospitals down on Friday and staff there is feeling burned out from adjusting to the furloughs.
- President Obama has nominated Pamela Hyde as the new administrator for SAMHSA. She is very familiar with many of these issues, and is passionate and committed. She is a "big picture thinker" who has run state and private programs.
- DMH has completed its publication on stigma and discrimination. It uses the same format as the suicide prevention plan and we hope to release that within the next week. It's a great document that really reflects the voices of our communities.

### **Questions/Answers and Discussion with Dr. Mayberg**

*Karen Hart:* My advancing grey hair is of concern; I was doing fine until you mentioned age on the Council.

**Answer:** We really need to look at bringing in younger folks as well as our seasoned veterans. The hardest part at state government is that a lot of people will retire because, with the furloughs, they actually would make more money retired than working. We should probably look at some TAY (transition-age youth) representation.

*Joe Mortz:* Earlier, I expressed my strong dissatisfaction with DMH regarding its data collection. I don't want to say this behind your back. I think the situation is we really

need to know what the public needs are – who is getting the services and who is not getting the services – so we can more effectively use our ever-decreasing funds.

**Answer:** You did fire up a lot of people with your comments. I think you are correct that, from a public health point-of-view, we do need to know prevalence and we need to know changes that have been made. And those requirements are in our cultural competence needs standards that we have asked counties to submit to us. I think that working collaboratively – we will all have to work on this.

I don't think it's an issue of incompetence but probably faulty data and prioritization. The information does need to be more front and center and the frustration is how do we get that information and how do we prioritize that with so many other things going on. I appreciate what you say and I appreciate that we have staff who will follow up on what you say.

*Lin Benjamin:* Regarding the vacancies on the Planning Council, we've heard some excellent presentations around co-occurring disorders and the importance of moving toward a service-integrated model. I'd like to see someone on the Planning Council with co-occurring disorders expertise.

**Answer:** I think that's an important point. Perhaps we can find a TAY with that expertise.

*Beverly Abbott:* Our Policy and Systems Development Committee spent a year looking at what counties are doing with MHSA and also have some recommendations regarding housing that don't cost money. I think they're very important to the Planning Council because we think housing and the community is a very important part of the MHSA.

**Answer:** Housing is a big deal. We did have a meeting between CMHDA, CalHFA and the DMH. CalHFA seemed very amenable to eliminating some of the bureaucratic steps. Please keep providing those insights.

*Daphne Shaw:* I'd like to comment about the data issues referenced earlier. We've been working on the Board Commission Workbook and identifying certain areas that we want data on that we want to take to the various boards and commissions. In the past year some of the specific data we need has been put together and is going forward. DMH has responded extremely well to our Quality Improvement Committee and our requests for information from them.

**Answer:** One of the things we're discovering is that we have the data and we think it's out there and it's not. We need to do a much better job of making sure it's available and accessible. As we have less administrative requirements we're going to be spending much more time accessing from the data. So the quality of the data becomes even more important.

*Luis Garcia:* I also want to talk about the data in the Latino Access Study. As you know, we have a significant gap across the state with communities of color. I think the next step is the action plan – based on the data, what are we planning to do? The frustration I have is that we've known about this issue for the last 20 years. With the data we already have it's very clear where we have to go and what the action plan is with the county and with the state. I know we have a lot of economic challenges right now but we

need to do something regarding the huge gaps in the system. MHSA is very clear that one of the core values is to reduce disparities and I hope that, with the data and a clear vision, we can prove that we are working consistently with the philosophy that MHSA has.

**Answer:** I agree with you that reducing disparities is a goal for all of us to address, wholeheartedly. There are two issues we have to look at – the data issue; and, why aren't people getting services. And there are two parts to that – are the services available, and are people feeling comfortable using those services.

Certainly last year, with the focus groups we conducted at UC Davis, we did find out what some of the community barriers are that have nothing to do with services as they are offered now; they have more to do with perception and stigma and discrimination issues that we have to address. And we've started those relationships with those communities and we need to continue with that.

Also, we've learned that many of the communities of color would prefer to get their services not in mental health and we have to look at being able to address where people are going to get services and build our system outside. So maybe that has to do with the integrated system that Dr. Pating talked about. People are apt to go to their primary care and we need to see how to work better with the other providers. Health care reform gives us that opportunity. So let's look beyond the data and see what some of the other barriers are that are stopping us from getting people the services they need.

*Luis Garcia:* The LAS didn't mention anything about the uninsured.

**Answer:** That's one of the flaws in our data collection. We look at the penetration rates and demographic information is often made around Medi-Cal claims. If it's not a reimbursable service we pretend it's not a service and it really is a service. I think there are ways to have outreach into diverse community that aren't necessarily psychotherapy and medication. This is, once again, another issue that the groups need to sit down and talk about.

*Adrienne Cedro-Hament:* I agree that we need to collaborate, and I haven't seen the level of collaboration we need. Does this kind of collaboration need to come from you or do we in the Council need to initiate that?

**Answer:** We always find a disconnect between data, policy and providers. It's a different world and different mindsets. I don't think it should be that the Director of Mental Health demands that the entities get together. There needs to be an agreement that this is important because any time we ask people to do more paperwork there is a pushback.

We need to show the utility of the data. If everyone understood why we need that and what we will be doing with it then it becomes a higher priority. We need to find the balance between the over-reporting of federal stimulus and the under-reporting that our system is doing right now.

## **10. New Business**

Joe Mortz requested an agenda item for the next steps with the IDDT program and co-occurring disorders. Patrick Henning noted that there is a co-occurring disorders paper that the OAC has put out that addresses those next steps.

Adrienne Cedro-Hament suggested initiating a follow-up process to determine how the collaboration process might evolve.

## **11. Adjournment**

Chair Mueller adjourned the meeting at 12:30 p.m.