



September 19, 2013

To: California Mental Health Planning Council

From: Jane Adcock  
Executive Officer

Subject: October 2013 Planning Council Meeting

Enclosed is the packet for the October 16-18, 2013 Planning Council meeting at the Red Lion - Woodlake in Sacramento, CA. The hotel is located at 500 Leisure Lane, Sacramento, CA 95815. The hotel provides complimentary (free) 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 go to 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 to your committee after presenting your issue request so the regular agenda items can be handled.

### **Mentorship Forum**

A Mentorship Forum will be held the evening of **Thursday, October 17**, 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 will be to discuss the process issues involved in chairing the committees and the Planning Council. For example, experienced chairs can explain the techniques they used during the day 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 hoped 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 50 minutes for committee reports on Thursday morning. The focus of the committee reports is to be what tasks or objectives the committee has completed on its projects 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

CHAIRPERSON  
John Ryan  
EXECUTIVE OFFICER  
Jane Adcock

- Advocacy
- Evaluation
- Inclusion

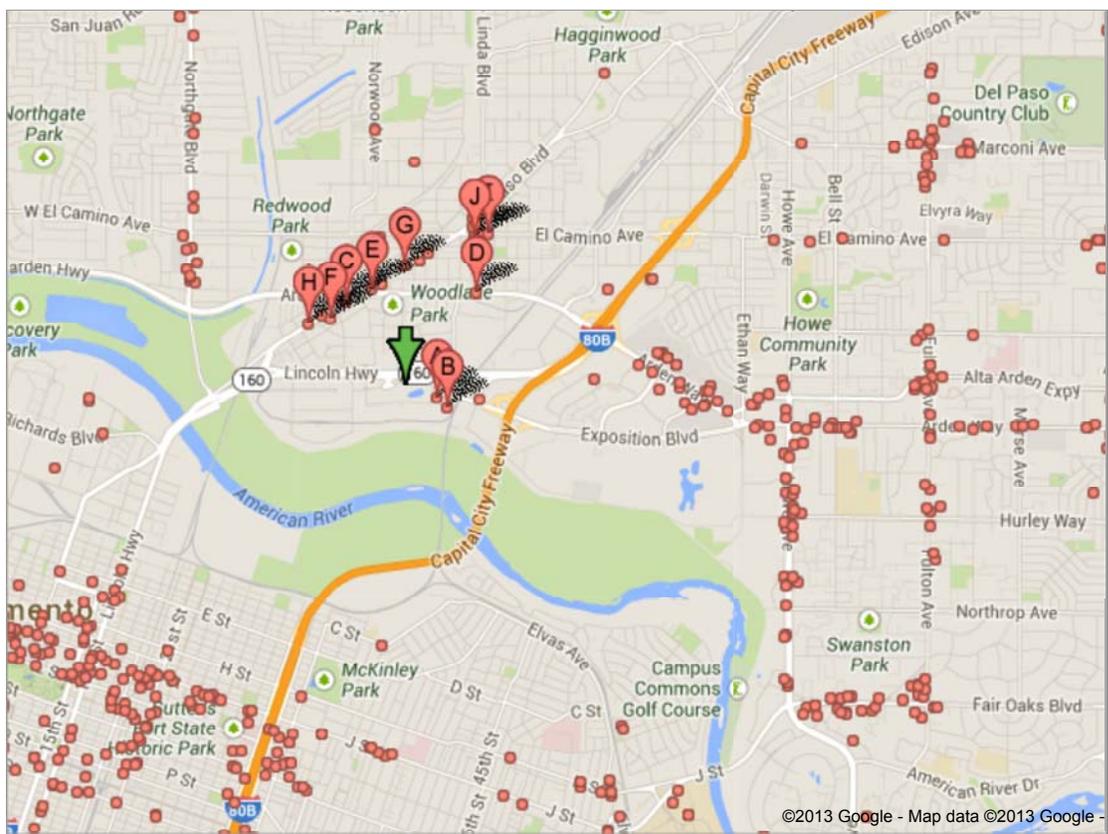
MS 2706  
PO Box 997413  
Sacramento, CA 95899-7413  
916.651.3839  
fax 916.319.8030





**restaurants near 500 Leisure Ln,  
Sacramento, CA 95815**

- A. **Extreme Pizza**  
1140 Exposition Blvd #200, Sacramento, CA  
(916) 925-8859  
4.6 ★★★★★ 9 reviews
- B. **Subway Sandwiches**  
1140 Exposition Blvd, Sacramento, CA  
1 review \$
- C. **Enotria Cafe & Wine Bar**  
1431 Del Paso Blvd, Sacramento, CA  
(916) 922-6792  
4.3 ★★★★★ 71 reviews \$\$
- D. **Chando's Taco**  
863 Arden Way, Sacramento, CA  
(916) 641-8226  
4.1 ★★★★★ 65 reviews \$
- E. **KFC / A&W Sacramento**  
1601 Del Paso Blvd, Sacramento, CA  
(916) 929-8253  
1 review \$
- F. **Stonney Inn**  
1320 Del Paso Blvd, Sacramento, CA  
(916) 927-6023  
3.9 ★★★★★ 11 reviews \$\$
- G. **The Green Boheme**  
1825 Del Paso Blvd, Sacramento, CA  
(916) 920-4278  
4.3 ★★★★★ 9 reviews
- H. **Uptown Cafe Inc**  
1121 Del Paso Blvd, Sacramento, CA  
(916) 649-2233  
3.9 ★★★★★ 15 reviews
- I. **Popeye's Chicken & Biscuits**  
901 E El Camino Ave, Sacramento, CA  
(916) 564-2778  
3.9 ★★★★★ 8 reviews \$
- J. **El Forastero Mexican Food**  
850 E El Camino Ave, Sacramento, CA  
(916) 925-1026  
3 reviews

















**AGENDA**  
**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**  
**October 16, 17, 18, 2013**  
**Red Lion Hotel - Woodlake**  
**500 Leisure Lane**  
**Sacramento, CA 95815**  
**Conference Call (Audio/Listen ONLY): 1-866-723-8689**  
**Participant Code: 8356601**

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 16, 2013**

**Room**

**Tab**

**Special Event**

8:00 a.m. Tour of CHCF in Stockton, CA (Optional and for  
to Council members only). RSVPs were completed  
12:30 p.m. 9/16/13 in order to secure necessary clearance to  
enter the correctional facility.

**COMMITTEE MEETINGS**

	Continuous System Improvement Committee	Edgewater B
1:30 p.m.	Advocacy Committee	Edgewater A
to		
5:00 p.m.	Health Care Reform Committee	Edgewater F
5:00 p.m.	Children's Caucus Meeting	
5:30 p.m.	Executive Committee	Edgewater A

**Thursday, October 17, 2013**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

8:30 a.m.	<b>Welcome and Introductions</b> <i>John Ryan, Chairperson</i>	Edgewater AB (combined)
8:40 a.m.	<b>Opening Remarks</b> <i>Dorian Kittrell, Sacramento County Behavioral Health</i>	
9:00 a.m.	<b>Approval of Minutes of June 2013 Meeting</b> <i>John Ryan, Chairperson</i>	<b>B</b>

**Thursday October 17, 2013 (Continued)**

		<b><u>Room</u></b>	<b><u>Tab</u></b>
9:10 a.m.	<b>Executive Committee Report</b> <i>Jane Adcock, Executive Officer</i>  All items on the Executive Committee agenda posted on our website are incorporated by reference herein and are subject to action.	Edgewater AB (combined)	
9:15 a.m.	<b>Council Member Open Discussion</b> <i>Full Council</i> <ol style="list-style-type: none"><li><i>1. Implications of MHSA Audit Findings</i></li><li><i>2. White Paper by Mental Illness Policy Organization</i></li></ol>		C D
10:00 a.m.	<b>BREAK</b>		
10:15 a.m.	<b>Committee Reports</b> <i>CSI Committee – Patricia Bennett, Chair</i> <i>HCR Committee - Beverly Abbott, Chair</i> <i>ADV Committee – Barbara Mitchell, Chair</i> <i>PR Committee - Daphne Shaw, Chair</i>		
10:55 a.m.	<b>Report from CA Mental Health Directors Association</b> <i>Robert Oakes, Executive Director, CMHDA (invited)</i>		
11:15 a.m.	<b>SAMHSA Update</b> <i>Jon Perez, Ph.D. Regional Administrator, Region IX Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services</i>		
12:00 p.m.	<b>LUNCH</b>		
1:30 p.m.	<b>CMHPC Mandates Work Plan</b> <i>John Ryan and All</i>		E
3:15 p.m.	<b>BREAK</b>		
3:30 p.m.	<b>Report from Dept. of Health Care Services</b> <i>Karen Baylor, Mental Health and Substance Use Disorders Services, Dept. of Health Care Services</i>		

**Thursday October 17, 2013 (Continued)**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

- |           |   |                            |
|-----------|---|----------------------------|
| 3:45 p.m. | <b>Report from Mental Health Services Oversight and Accountability Commission</b><br><i>Sherri Gauger, Executive Director</i> | Edgewater AB<br>(combined) |
| 4:00 p.m. | <b>Celebration and Acknowledgement of Outgoing Members</b><br><i>Full Council</i>   |                            |
| 4:30 p.m. | <b>Public Comment</b><br><i>John Ryan, Chairperson</i>  |                            |
| 4:50 p.m. | <b>New Business</b><br><i>John Ryan, Chairperson</i>  |                            |
| 5:00 p.m. | <b>RECESS</b>   |                            |

Mentorship Forum for Council members including Committee Chairs and Vice Chairs will occur immediately following the adjournment of Thursday's General Session.

**Friday, October 18, 2013**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

- |           |   |                            |
|-----------|---|----------------------------|
| 8:30 a.m. | <b>Welcome and Introductions</b><br><i>John Ryan, Chairperson</i>   | Edgewater AB<br>(combined) |
| 8:40 a.m. | <b>Opening Remarks</b><br><i>Chris Hunley, Chair, Sacramento County MH Board</i>  |                            |
| 9:00 a.m. | <b>Report from the California Association of Local Mental Health Boards/Commissions</b><br><i>Mike Gonzales, President</i>  |                            |
| 9:20 a.m. | <b>Overview of Workforce Education and Training Draft 5-Year Plan and Discussion</b><br><i>Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development, OSHPD and Sergio Aguilar, Project Manager, WET 5-Yr Plan, OSHPD</i> |                            |



**October 16, 2013**

**1:30 to 5:00 p.m.**

Red Lion Inn – Woodlake  
500 Leisure Lane  
Sacramento, CA, 95815  
1-866-539-0036

ITEM #	TIME	TOPIC	TAB	PAGE
1.	1:30	Introductions and Agenda Review <i>Gail Nickerson, Co-Chair</i>		
2.	1:35	New Business <i>Adam Nelson, Co-Chair</i>		
3.	1:45	Review and Approve Minutes <i>Gail Nickerson, Co-Chair</i>	A	<b>19</b>
4.	1:50	MFTs – Recognition by Medicare <i>Sara Kashing, MFT, California Marriage and Family Therapists</i>	B	<b>25</b>
5.	2:50	<i>Discussion and next steps</i>		
	3:00	Break		
6.	3:20	The SPA and the Peer Certification Process <i>DHCS Representative (Invited)</i> <i>Gail Nickerson, Co-Chair</i>	C	<b>35</b>
	4:20	<i>Discussion and next steps</i>		
7.	4:30	Finalization of Position Statements <i>Adam Nelson, Co-Chair</i>	D	<b>43</b>
8.	4:40	W3 (who does what by when) <i>Gail Nickerson, Co-Chair</i>		
9.	4:45	Develop Report Out for General Session <i>Adam Nelson, Co-Chair</i>		
10.	4:50	Plus/Delta <i>Gail Nickerson, Co-Chair</i>		
11.	4:55	Plan Agenda for next meeting <i>Andi Murphy, Staff</i>		

**Committee Members:**

**Co-Chairs:** Barbara Mitchell  
**Vice – Chair:** Adam Nelson

Gail Nickerson

John Ryan  
Monica Wilson  
Stephanie Thal  
Karen Bachand  
Caron Collins

Sandra Wortham  
Nadine Ford  
Daphne Shaw  
Chloe Walker

**Staff:** Andi Murphy



**Continuous System Improvement Committee  
AGENDA  
Red Lion Woodlake  
500 Leisure Lane  
Sacramento, CA 95815  
1:30 p.m. to 5:00 p.m.**

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

	<b>Room</b>	<b>Tab</b>
1:30 p.m.      Planning Council Member Issue Requests	Edgewater B	
1:35 p.m.      Welcome and Introductions <i>Patricia Bennett, Ph.D., Chair</i> <i>Susan Wilson, Vice-Chair</i>		
1:40 p.m.      Review and Approve April 2013 Minutes		
1:45 p.m.      Presentation: MHSOAC Activities <i>Renay Bradley, PhD, Director of Research &amp; Evaluation,</i> <i>MHSOAC</i>		
2:30 p.m.      Questions/Comments		
3:00 p.m.      Break		
3:15 p.m.      Work Plan Review: Discuss Future Presenters		
3:30 p.m.      Discussion: CMHPC Mandates Plan <i>Patricia Bennett, Ph.D., Chair</i> <i>Susan Wilson, Vice-Chair</i>		<b>A</b>
3:50 p.m.      Discussion: MHSOAC Evaluation Master Plan Comments		<b>B</b>
4:15 p.m.      Update on Data Notebook <i>Susan Wilson, Vice-Chair</i>		
4:45 p.m.      Evaluate Meeting/Develop Agenda for Next Meeting <i>Patricia Bennett, PhD, Chair</i> <i>Susan Wilson, Vice-Chair</i>		
5:00 p.m.      Adjourn Committee		

**COMMITTEE MEMBERS**

Patricia Bennett, PhD, Chair  
Susan Wilson, Vice-Chair  
Adrienne Cedro-Hament  
Amy Eargle  
Lorraine Flores  
Karen Hart  
Celeste Hunter

Carmen Lee  
Monica Nepomuceno  
Jeff Riel  
Walter Shwe  
Bill Wilson



**AGENDA**  
**Healthcare Reform Committee**  
**Wednesday, October 16, 2013**  
**Red Lion Woodlake**  
**500 Leisure Lane**  
**Sacramento, CA 95815**  
**1:30 p.m. to 5:00 p.m.**

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

		<b>Room</b>	<b>Tab</b>
1:30 p.m.	Planning Council Member Issue Requests	Edgewater F	
1:35 p.m.	Welcome and Introductions <i>Beverly Abbott, Chairperson</i>		
1:40 p.m.	Update: Cal Medi-Connect <i>Brenda Grealish, MHS Division Chief, DHCS</i>		<b>A</b>
2:20 p.m.	Update: Behavioral Health Service Needs Plan <i>Jaye Vanderhurst, LCSW</i>		<b>B</b>
2:45 p.m.	Update: Health Homes <i>Steven Grolnic-McClurg, LCSW, Co- Vice Chairperson</i>		
3:15 p.m.	Break		
3:30 p.m.	Exchanges and the Uninsured <i>Molly Brassil, CMHDA : Invited</i>		
4:15 p.m.	Healthy Families shift to Medi-Cal <i>Cindy Claflin, Co-Vice Chairperson</i>		
4:45 p.m.	Next Steps/Develop Agenda for Next Meeting <i>Steven Grolnic-McClurg, LCSW, Co- Vice Chairperson</i>		
4:55 p.m.	Wrap up: Report Out/ Evaluate Meeting <i>Steven Grolnic-McClurg, LCSW, Co- Vice Chairperson</i>		
5:00 p.m.	Adjourn Committee		

**COMMITTEE MEMBERS**

Beverly Abbott, Chair	Doreen Cease	Joseph Robinson
Steven Grolnic-McClurg, Co-Vice Chair	Suzie Gulshan	Cheryl Treadwell
Cindy Claflin, Co-Vice Chair	Terry Lewis	Jaye Vanderhurst
Josephine Black	Dale Mueller	





September 16, 2013

To: Executive Committee
From: Jane Adcock, Executive Officer
Subject: Agenda for Executive Committee Meeting
Wednesday, October 16, 2013 5:30 p.m.
Red Lion Inn-Woodlake
500 Leisure Lane, Sacramento, CA 95815
Room: Edgewater A Conference Room

CHAIRPERSON John Ryan
EXECUTIVE OFFICER Jane Adcock

The Executive Committee meeting will address the following items. All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

- Advocacy
Evaluation
Inclusion

Table with 3 columns: TIME, AGENDA, TAB. Rows include items like 'Review and approve minutes from the June, July, August 2013 Executive Committee Meetings' and 'Executive Committee Review of draft CMHPC Mandates Work Plan'.

Executive Committee Members

<b>Chair</b>	John Ryan	<b>Health Care Reform</b>	Beverly Abbott
<b>Past Chair</b>	Gail Nickerson	<b>Advocacy</b>	Barbara Mitchell
<b>Chair Elect</b>	Monica Wilson	<b>Patients' Rights</b>	Daphne Shaw
<b>CSI</b>	Patricia Bennett	<b>At Large Consumer</b>	Walter Shwe
<b>CMHDA Liaison</b>	Jaye Vanderhurst	<b>At Large Fam Memb</b>	Karen Hart
<b>CALMHB/C Liaison</b>	Susan Wilson	<b>Executive Officer</b>	Jane Adcock

INFORMATION

TAB SECTION:           **B**

  X   ACTION REQUIRED:

DATE OF MEETING: 10/16/13

Approve minutes from the June 2013 Meeting

DATE MATERIAL

PREPARED BY: Thompson

PREPARED: 09/17/13

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AGENDA ITEM: Approval of the Minutes of the June 2013 Meeting

ENCLOSURES:     • June CMHPC 2013 Minutes

OTHER MATERIAL RELATED TO ITEM:

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ISSUE:



# CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

**June 20 and 21, 2013**  
**Hilton San Francisco Airport Bayfront**  
**600 Airport Boulevard**  
**Burlingame, CA 94010**

## **CMHPC Members Present:**

Monica Wilson, Ph.D., Chair	Barbara Mitchell
Beverly Abbott	Dale Mueller
Karen Bachand	Monica Nepomuceno
Josephine Black	Adam Nelson, M.D.
Doreen Cease	Gail Nickerson
Adrienne Cedro-Hament	Deborah Pitts, Ph.D.
Caron Collins (Thursday only)	Joseph Robinson
Michael Cunningham	Patricia Santillanes
Amy Eargle, Ph.D.	Daphne Shaw
Lorraine Flores	Walter Shwe
Steven Grolnic-McClurg	Stephanie Thal
Karen Hart	Jaye Vanderhurst
Celeste Hunter	Chloe Walker
Carmen Lee	Bill Wilson
Terry Lewis	Sandra Wortham

## **Staff Present:**

Jane Adcock, Executive Officer	Andi Murphy
Linda Dickerson	Narkesia Swanigan
Michael Gardner	Tracy Thompson

## **Thursday, June 20, 2013**

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

Chair Monica Wilson brought the meeting to order. She requested the Planning Council members and the audience to introduce themselves.

Executive Officer Jane Adcock welcomed Deborah Pitts, the newest Planning Council member. Dr. Pitts outlined her background. A professional therapist by education, she teaches in the Professional Education program at USC. She has worked in community mental health for 35 years, and has been involved in appointment programs, housing programs, and community-based mental health teams.

### **2. Opening Remarks**

The representative from the San Mateo County Mental Health Board was not present.

### **3. Approval of the Minutes of the April 2013 Meeting**

**Motion:** The approval of the April 2013 Meeting Minutes was moved by Beverly Abbott, seconded by Adrienne Cedro-Hament. Motion passed with two abstentions.

Chair Wilson stated that a quorum had been achieved.

### **4. Executive Committee Report**

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

- Currently there was one vacancy on the Planning Council for a Direct Consumer position.
- The financial outlook for the state is fairly favorable. The state will be reinstating dental benefits under the MediCal program; the Planning Council had been supporting this move and had sent several letters.
- Members of the Executive Committee had met with Toby Douglas, Director of the Department of Health Care Services (DHCS), to begin the conversation on the relationship of that organization with the CMHPC.

Brenda Grealish has been hired as DHCS Mental Health Director. DHCS has announced the replacement for Deputy Director Vanessa Baird: Karen Baylor, who has been serving as Director of Mental Health for San Luis Obispo County.

- Executive Officer Adcock will be establishing a temporary Ad Hoc Committee to work closely with colleagues at the Office of Statewide Health Planning and Development (OSHPD) on the development of the Five-Year Workforce Plan, due April 1, 2014. Executive Officer Adcock will be seeking volunteers to serve on the committee.
- The Bureau of State Audits has come out with the draft review of the Mental Health Services Act (MHSA). The Planning Council will obtain its segment on Friday for review and comment, which will be highly confidential. Executive Officer Adcock requested volunteers; Caron Collins, Lorraine Flores, and Stephanie Thal responded.
- Executive Officer Adcock arranged for a listen-in capability for CMHPC meetings. The CMHPC will continue the listen-in capability for future meetings.

### **5. MHSA WET Focus Group**

Lupe Alonzo-Diaz, Deputy Director for the Healthcare Workforce Development Division at OSHPD, gave the presentation. She explained that OSHPD is responsible for developing the next Five-Year Workforce Plan for 2014-2019; CMHPC's role is to review and approve the plan.

To obtain stakeholder feedback, OSHPD has conducted 14 community forums, 11 focus groups, and a number of key stakeholder interviews. OSHPD has also done webinars and surveys to which the CMHPC has had access.

Sergio Aguilar, Project Manager for the Workforce Education and Training (WET) Five-Year Plan, set the context for the focus group.

- One of the elements included in the MHSA was to address some of the mental health workforce challenges, known as the WET component.
- In 2008, the Department of Mental Health (DMH) developed the first Five-Year Plan. It provided strategies and funding principles. A total of \$444.5 million was initially allocated for this component of the MHSA. \$210 million of that went to the counties for their own local WET efforts. The remaining \$245 million was allocated to DMH for state-administered WET programs.
- DMH developed six programs to be administered at the state level:
  1. Stipend programs to provide licensing for mental health professionals, and for institutions to change curriculum to add MHSA values.
  2. The mental health loan assumption program provides loan repayments to individuals going into hard-to-fill and hard-to-obtain positions within the county mental health system.
  3. The Song-Brown Residency Program trains physician assistants to work in mental health.
  4. The Psychiatric Residency Program trains psychiatric residents.
  5. The Client and Family Member Statewide Technical Assistance Center, also known as Working Well Together helps to promote the employment of consumers and family members within the public mental health system.
  6. The development of regional partnerships with the five regions of California.
- In July of 2012, with the elimination of DMH, the different mental health functions were given to different agencies. OSHPD took over the WET functions as well as the responsibility for developing the next Five-Year Plan.
- Elements that must be included in the Five-Year Plan, per the statute, are:
  - Examine educational capacity.
  - Examine stipends, scholarships, training, recruitment, etc.
  - Examine issues of diversity and cultural competency.
- The stakeholder engagement process is substantial, as referenced by Ms. Alonzo-Diaz.

Dale Mueller noted that all of the questions asked the Planning Council members to comment on county or regional needs. However, many Planning Council members look at statewide needs rather than local needs. She queried as to whether a broader answer would be helpful. Mr. Aguilar and Ms. Alonzo-Diaz answered that statewide needs are definitely relevant.

Mr. Aguilar reviewed the questions and obtained feedback from Planning Council members.

**Question # 1** asked about the broadest challenges and priorities for the mental health workforce.

- Barbara Mitchell responded that in Monterey County, there is an extreme shortage of psychiatrists, psych nurses, and psych technicians. The other issue is that wages are low for people working in residential treatment, and as BA-level counselors; but the level of skill required to do the work, especially the MediCal documentation, is fairly high.

Ms. Mitchell asked about the outcome of Working Well Together statewide – how many consumer positions have been developed in county programs? She noted that Monterey County has very few consumer positions. In addition, there is a need for part-time positions.

- Adrienne Cedro-Hament agreed that the workforce problem is huge. More psychiatrists, psych techs, psych nurses, and MSWs, are needed, as well as California Social Work Education Center (CalSWEC) scholarships.

Ms. Cedro-Hament added that in Los Angeles, there are not enough providers who can speak the 13 primary languages. Therapy needs to be done in the native language of the consumer.

California's licensure impedes interstate reciprocity for employees; this issue could be examined. Further, we have a need to increase the language capability of providers by employing those with foreign credentials.

- Monica Nepomuceno saw a gap in the workforce specializing in children's services, specifically school-based services. There is a huge need for school-based social workers. She also agreed with the need for bilingual, bicultural staff across the board.
- Bill Wilson stated that consumers with lived experience should be used in the workforce. They can work with providers to be a part of the wellness solution.
- Ms. Mueller agreed with Ms. Cedro-Hament. She continued that in the higher education pipeline, people from the OSHPD side need to take part in decisions made by deans and directors as to what programs to add and delete. Ms. Mueller suggested a quarterly bulletin for decision-makers in higher education, so they don't have to go to special meetings to find out what the needs are.
- Michael Cunningham spoke of increased integration between primary care, mental health and substance use disorders, as well as the high level of co-occurring disorders: it is important for practitioners to have the necessary knowledge and qualifications to treat both diseases and disorders. Accordingly, we should look at the curriculum within educational institutions; it should have a focus on co-occurring disorders and how they manifest themselves in different populations.

- Stephanie Thal stated that Marriage and Family Therapists both statewide and nationally have been working for years toward trying to get Medicare reimbursement. It hasn't happened yet. Any assistance in the effort to get Medicare reimbursement for MFTs would be appreciated.
- Adam Nelson, M.D. noted that many psychiatrists feel that the mental health field has been conspicuously absent from policy and program development over the years. Psychiatrists have concerns that in the absence of sufficient psychiatric services, as well as other vitally necessary professional services, there has been a growing trend toward backfilling those growing deficiencies with personnel and resources that may not be adequately trained.

Fellow psychiatrists had provided Dr. Nelson with the following suggestions for how OSHPD could help improve the system.

- Improve coordination of currently available resources. A statewide network embracing current technology could be developed, e.g., tele-psychiatry and tele-mental health services to reach out to vitally underserved communities and counties.
- Address the tendency for California mental health services to be provided through various silos of specialized services. Services for co-occurring disorders of substance use and mental illness as well as co-occurring disorders of developmental disorders and mental illness need to be implemented.
- Find a way for psychiatrists and other highly-qualified specialty disciplines and services to be more actively included in the development and implementation of programs. There is no reimbursement structure enabling mid-level practitioners – nurse practitioners, physician's assistants and others, who would be more readily available in local communities – to coordinate services with psychiatrists. Psychiatrists would like to see consultation encouraged through such technologies as tele-psychiatry and tele-mental health services.
- Jaye Vanderhurst concurred with all of the comments thus far. She supported Ms. Thal's comment about recognizing MFTs and other disciplines as providers, particularly as we face an aging population. The ebb and flow of county funding needs to be protected by maximizing appropriate revenue.

She mentioned another twist to look at in the challenges for small counties: having clinicians want to accept leadership responsibilities and be part of policy and program development.

- Josephine Black said that the Americans with Disabilities Act requires that all community programs are accessible to and usable by people with disabilities. When practitioners are faced with a person in a wheelchair, or a person who is deaf, low-vision, blind, or has some other significant condition that impacts life activities, the practitioners tend to hang everything about that person on the hook of disability. They need to be trained and sensitized.

- Celeste Hunter agreed with Ms. Mitchell that one of the major concerns of family members and consumers working in the field is MediCal billing. When they were hired they were not aware that this would be a job duty, and it can be another stressor – taking away from navigating, encouraging, and helping people toward self-sufficiency.

Professional growth is another issue. Usually people stay in the position for which they were hired – but family members and consumers need opportunities for professional growth.

Front-line service providers need cross-training so they can understand the roles of family members and consumers. They also need to break down personal barriers in order to build relationships and trust.

Some family members and consumers may have criminal records. When they apply for positions for which they are well-qualified, at some agencies it comes back to bite them. That needs to be remedied.

- Beverly Abbott addressed the career path issue. The chance to move up through the system all the way to leadership is important. Some people should be retained no matter where they started from. Ms. Abbot added that it is important to know what was learned from Working Well Together.
- Deborah Pitts said that in other countries, occupational therapists are present in mental health systems. However, in the U.S., they are not the strongest players although they are among the oldest. Mental health agencies need to consider incorporating occupational therapists. State Medicaid has the option to decide who can be considered a Licensed Mental Health Practitioner (LMHP) for its reimbursement of public mental health services.
- Carmen Lee commented that it is important for consumers and family members to develop some sort of uniform syllabus curriculum. People shouldn't come from their own stigmatizing opinions.
- Walter Shwe stated that in traveling around the state for his job, he sees consumers and family members working in the system who are limited to one or two positions specifically for them. There is no real opportunity for them to work up the ladder and get promotions. Further, loans, scholarships, or other incentive programs could specifically target consumers and family members working in the system.

Mr. Aguilar interjected that OSHPD is currently evaluating all six programs, including Working Well Together. The resulting informational briefs will play a part in the development of the Five-Year Plan.

- Ms. Mueller mentioned that in the higher education pipeline, there are acute shortages of qualified faculty.
- Ms. Mitchell asked when the outcome measurements will be available; Mr. Aguilar responded that although there is no set date, it will be before the Five-Year Plan is reviewed and approved.

**Question #2** asked specifically what types of workforce will be needed to address public mental health workforce needs, including competencies, education, and credentials.

- Gail Nickerson stated that in rural areas the workforce is very limited and almost every kind of service is needed. Tele-health is one of the solutions. The rural areas need social workers, psychiatrists, nurse practitioners – anyone who can provide services and is licensed. If we cannot connect to them locally, we would like to use technology.
- Ms. Mitchell stated that we need a training program for those who are going to work in administration of programs, who understand mental health finance, contracts, program design, etc. We have an aging workforce of managers, and it is difficult for some of them to understand mental health finance issues.
- Ms. Vanderhurst stated that we need to look at graduate program competencies regarding the wellness concept. Mental health and substance use needs to be blended with health care.

In addition, computer and technology competency needs to be developed early in the workforce. Electronic health records are sophisticated and those doing documentation need the skills to use them.

- Doreen Cease expressed the need to get junior high school and high school students involved in mental health. Organizations in the high schools could train students how to talk with their peers in an effort to prevent suicides.
- Joseph Robinson emphasized the importance of competencies. In the past there has been an overemphasis on formal education and credentials. Because of the anticipated numbers of people coming into the system, it is essential to pay attention to who can do the job, and not use licensed staff for work that could be done by unlicensed staff.
- Mr. Wilson emphasized the importance of lived experience as well as education.
- Terry Lewis agreed with Mr. Robinson that there has been a push to hire licensed people – but they lack the competencies that come with history. Much of this push is directly tied to financing and writing billable notes. Job descriptions need to require mental health experience in public policy.

Ms. Lewis had observed that there's no effort to fund hiring of counselors with Pupil Personnel Services (PPS) credentials in child welfare and attendance, who could engage students who are talking about suicide.

- Karen Hart assured the Planning Council members that Working Well Together has been working for two years on peer certification, with four types of peers: Parent Caregiver of Child and Youth, Transition Age Youth, Clients, and Families of Adult Clients. This certification could free up the specialties to do the work within their particular licensure.
- Mr. Cunningham commented on the importance of the inclusion of people with lived experience and people in recovery, in the integration of mental health with

primary care. Their knowledge, skills, and competencies should be brought to the medical team setting.

A major emphasis in health care reform is prevention and wellness; what are the competencies, training, and skill sets required to integrate prevention at the broader community level as well as the individual level?

- Ms. Thal first mentioned that the California Association of Marriage and Family Therapists (CAMFT) has historically encouraged the combination of an MFT with PPS credentials.

She continued that it is essential to bring the prevention concept to young students early on.

**Question #3** looked at employment of consumers and family members in the public mental health system, including barriers and recommendations.

- Ms. Cedro-Hament spoke of the experience of employing trained consumers in Los Angeles – it turned out that staff needed to be trained in accepting them. The staff actually perpetuated the stigma. Further, once consumers are accepted into the system, they need to have some kind of support.
- Dr. Nelson shared comments from fellow psychiatrists. The main concern they have in integrating peer and family peer counselors is confidentiality. Exposure of information from consumer records within the mental health community can become an unintended barrier.

Another concern is that stigma may continue to pervade the workplace, even in subtle ways. Adequate supervision and liaison among the groups could mitigate the problem.

The other issue is accurate diagnosis. With the recent release of the Diagnostic and Statistical Manual of Mental Disorders, Edition 5 (DSM-5), there is a growing concern within the mental health community about both underdiagnosis (which limits access to services) and overdiagnosis. It is even more important to increase people's understanding of what is and isn't mental illness, so that people requiring services can get the most reliable and accurate services.

- Chloe Walker had noticed that with Transition-Age Youth (TAY) peer employees who are going to school, there are no incentives to continue. School can become a second priority if work is the first priority. She added that when consumers are asked to speak about their personal experiences, they should be paid as any other professional speaker would.
- Ms. Flores shared an example of the value of peer mentoring programs in Santa Clara. One of the biggest issues they had was peer staff falling in love with peer clients – that created a dual relationship. They also learned that the young people need continued supervision and mentoring.
- Ms. Mitchell described a model in Monterey County where a workforce education training coordinator works with consumers and family members who work both

for the nonprofit agency and in the public mental health system. It has greatly helped with retention of consumers in the workforce. The downside is that employees are paid by the hour for attending training, even when they work part-time – training hours take the place of productive hours.

Mr. Aguilar and Ms. Alonzo-Diaz thanked the Planning Council members for providing their insightful feedback. It was the first of various opportunities they will have; OSHPD will be engaging them on a regular basis.

## **6. Committee Reports**

### **Health Care Reform (HCR) Committee**

Committee Chair Beverly Abbott reported on what had changed in health care reform since the last meeting.

- MediCal expansion is due to be implemented in January 2014. The committee was pleased that the state made the decisions to have a state-administered program, and to make the benefit that is available to people with mental illness now, available to the MediCal expansion population.
- Regarding the behavioral health services plan, which has still not been done (and is supposed to have a workforce component), counties are going ahead and not waiting. The HCR Committee made the point that for the workforce component, what OSHPD is doing should dovetail with what the Department of Health Care Services is doing.
- The dual eligible (MediCal and Medicare) initiative, called Cal MediConnect, is moving forward.
- The California Health Benefit Exchange, called Covered California, sent out their request for health plans to apply. They had a very good response and a number of health plans are approved through the exchange. They will offer affordable insurance to everyone above 140% of poverty.
- Regarding children's services, Healthy Families has folded into MediCal. Someone is going to be doing advocacy work, looking at what has happened to children's services (EPSDT, Healthy Families, managed care, etc.) since all of these changes.
- Regarding Health Homes, the HCR Committee was given a presentation by Sandra Goodwin describing what has come out of the California Institute for Mental Health (CiMH) initiative integrating primary care and mental health care.

All presentations will be posted to the Health Care Reform Committee website.

### **Patient Rights (PR) Committee**

Chair Daphne Shaw reported on the following activities.

- Committee members had obtained information from their resident counties on patient rights. Staffer Michael Gardner was reviewing the information for commonalities.

- There are many areas of patient rights that the committee needs to discern, among them:
  - Rights for people involuntarily held
  - Treatment rights
  - MediCal grievance processes
- The committee looked at the Welfare and Institutions Code as it relates to patient rights. Under Section 5520, it discusses county Mental Health Directors appointing or contracting for services for one or more county patient rights advocates; it lists five duties for those advocates. The PR Committee is seeking to find out what counties are doing regarding the five duties.

### **Continuous Systems Improvement (CSI) Committee**

Ms. Cedro-Hament reported that the committee had discussed three main topics:

- The Mental Health Services Oversight and Accountability Commission (MHSOAC) Evaluation Master Plan. The CSI Committee will review it and provide feedback.
- AB 114 regarding children's issues.
- Issues from the workplan.

### **Advocacy Committee**

Ms. Mitchell reported on the following.

- Two major interests that the committee has worked on are in the state budget at this point: restoration of dental services and more funding for crisis residential programs as well as mobile crisis teams.
- The committee had had a presentation on federal and state policy changes having to do with homeless funding and programs. There have been many changes in the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, which governs the continuum of care programs which in turn fund many of the homeless services.
- The committee is trying to write policy statements on issues of mental illness and violence, and alternatives to institutional care.
- The committee sent a letter of opposition on SB 585, Steinberg's bill on Laura's Law. Yee's bill, which contained provisions removing the requirement for a Board of Supervisors to do a public hearing specifically before implementing Laura's Law, had ended up being folded into Steinberg's bill.

## **7. SAMHSA Update**

Jon Perez, Ph.D., Regional Administrator, Region IX Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, gave the presentation. Below is a summary.

## **SAMHSA Budget**

The budget for this fiscal year is approximately \$3.3 billion. Of that, California got about \$409 million: \$318 million for block grants before sequester and another \$90 million in discretionary funds.

## **Sequester**

The 2013 budget shows a significant drop from the previous year due to the sequester. For SAMHSA, the sequester meant a 5% across-the-board cut: about \$16 million for block grants. However, not only were these funds taken out of operating budgets, but spending plans had to be approved for the sequestered amounts.

## **Continuing Resolutions/Overall Budget Picture**

The spending plans were not approved until about ten days ago. That means the block grant funds for the state of California have not gotten here.

Currently, spending plans have been approved. SAMHSA was able to release about \$5 million to California to help cover some of the expenses being incurred by the counties and the state until the funds can get here.

Presently there is no federal budget passed for 2014. Hearings have not even been called. Dr. Perez felt that because of the deep entrenchment between the parties, this budget may go into a continuing resolution and SAMHSA state funding will be on the monthly plan again. For planning purposes, Dr. Perez suggested for the CMHPC to look at the worst case scenario – sequester being built in to the new budget for next year based on the current 2013 level.

On a more positive note, SAMHSA as an agency in the Administration, more generally, has put mental health/substance use on the map. The California state budget shows this in terms of parity, the expanded MediCal population, its connection with the exchanges, and so on. Mental health/substance use treatment is back, and it is supported all the way to D.C. Dr. Perez added that the parity final rule is getting much closer.

## **Expansion**

California is leading the nation in health reform, expansion, regulatory language, funding, etc. The other states are watching what California is doing with expansion.

People with behavioral health issues tend to cost more in terms of their expenditures for health care.

Dr. Perez showed a variety of graphs concerning the populations that will have new coverage options and be entering the system, and the costs. Nationwide, the total number of people benefitting from parity issues – that is, mental health being treated the same as the rest of health care – will be 62-63 million.

For California, Dr. Perez gave the following expansion numbers:

- Medicaid expansion population and insurance exchange population: 60,000+
- Psychological distress: 155,000

- Substance use prevalence: 175,000-180,000
- Behavioral health specifically: about 1.5-2 million total

The good news is that these people now have coverage. The bad news is how to manage all these people new to the system.

In considering where to put effort and strategic support for the next six months, SAMHSA conducted interviews with public and private entities in states and counties. The challenges and barriers to health reform are that it is very complicated; people don't understand it; and clear federal and state guidelines are not established.

SAMHSA is putting its energy into distilling the information and informing people.

(Ms. Abbott clarified the term *churn*: it refers to people who are going in and out of MediCal. Churning may worry and confuse people.) Dr. Perez added that people being able to come in and off of the plans is going to be a significant area of concern, particularly in the MediCal population and the exchange population.

The important take-home is that people are going to be getting information from trusted sources – not necessarily a government agency, but perhaps a clinic, a treatment team, and so on. SAMHSA needs to disseminate information through those channels.

SAMHSA is collaborating with national organizations in five areas: providers, criminal justice, consumer/family/peer recovery agencies and programs, housing support/homeless services, and community-based prevention organizations.

The website [healthcare.gov](http://healthcare.gov) is re-launching on Monday, June 24. The site has been much improved. They will also have a 24/7 live support capability for people with enrollment questions.

### **Questions/Discussion**

Ms. Abbott clarified that of the 1.5-2 million people entering the system in the next six months, some of those are currently getting indigent care. There will probably be lag time between when people get insurance and realize they can get a mental health/substance abuse benefit, and when they actually enroll.

Ms. Abbott also requested that when the Planning Council members' organizations start to receive materials in July and August, to let Narkesia Swanigan know. They should also let her know what they think about the materials.

Ms. Lewis asked if SAMHSA has considered using advocates in terms of letter-writing campaigns to put pressure on the Hill regarding the barriers and challenges. Dr. Perez replied that as an agency in the Executive Branch of the federal government, SAMHSA does not advocate or lobby. It is the advocates' role – that is, the CMHPC – to knock on the doors.

Ms. Nickerson pointed out that of the total amount that the CMHPC spent last year, 47% came from the SAMHSA block grant. She thanked SAMHSA.

## **8. Alternatives to Institutional Care**

Ms. Mitchell, Co-Chair of the Advocacy Committee, stated that the committee had planned three presentations.

A major focus of the committee is encouraging alternatives to institutional treatment or involuntary treatment. The first presentation featured two evidence-based models that promote either shortening involuntary treatment or avoiding it completely.

Co-Chair Mitchell introduced Steve Fields as the Director of Progress Foundation, a non-profit mental health agency in San Francisco that was one of the first to provide alternatives to institutional treatment. She introduced Paul Taylor as the Director of Momentum, another model program, in Santa Clara County.

### **Progress Foundation**

Mr. Fields said that the vast majority of California counties have yet to open a crisis residential program. He identified the fundamental outrage about the mental health system in the state: counties continue to invest in high-cost emergency care and hospital care, and their only creative alternative for four decades has been to join with the skilled nursing industry and trans-institutionalize clients to institutions for mental disease (IMDs).

All of the counties pay obeisance to the peer support and recovery concepts. However, fundamentally it is overwhelmingly an institutional system. At some point, this is going to change by necessity.

Mr. Fields' philosophy has always been that the way we treat the mentally ill is first a civil rights issue, then a human rights issue; the medical establishment impedes the treatment of people in a humane, logical, and community-based way.

Progress Foundation's goal has been to look at the high end of the system: what are we doing to people at the point they need the most support? He has always believed that hospitalization has to be a last resort: it isn't going to change the circumstances of a client's life, but is only going to help contain an imminent, present crisis.

Mr. Fields' objective is to open a program that keeps people from going into the hospital in the first place, that embodies the values learned at the residential treatment level of care rather than institutional values. The residential treatment values are:

- Human scale and familiarity: people are living in familiar environments when they are asked to take risks and challenges
- Staff can come from all walks of life
- Individual plans must be taken from the clients themselves
- Human values first and technological capability second

Mr. Fields described opening the first continuum of care in the Mission District. Client choice became the critical arbiter for whether services would be used or not.

He believed in “practice-based evidence” – “evidence-based practice” stifles creativity.

### **Momentum for Mental Health**

Mr. Taylor focused his presentation on a particular program: FSP 90, with *FSP* meaning *Full Service Partnership* and *90* being the maximum length of stay. Mr. Taylor cherry-picked the staff; some are former public guardians.

In the program, staff is deployed into IMDs. They can talk to anyone they want to. The county can steer staff to anyone they wish, or staff can talk to anyone of their choosing. They seek people who want to move out of the IMD (or in some cases, people who do not). The pace is based on the clients and their interests.

The hope is to get people into the community and to sustain them there. FSP 90 is a concurrent service: when the person comes out of the IMD, or the Emergency Room or Inpatient Unit, they are open to their traditional outpatient provider. FSP 90 works with them the same as they work with the client.

FSP 90 staff does all they can to get data. Mr. Taylor showed data they have compiled.

Mr. Taylor has also started a Foundation for Mental Health.

## **9. Follow-Up Questions/Discussion**

Ms. Abbott asked the two speakers to comment on Laura's Law. Mr. Fields believed that that particular movement only makes sense after the counties of California have opened up services for choice that would substantially change people's ability, willingness, and continuity in engaging services. He thinks it is the wrong approach. It would be a huge setback in the development of community services if we have that particular tool getting us off the hook in developing appropriate services.

Mr. Taylor felt that the laws in California are sufficient for the rare and unusual occasions where it is appropriate and necessary for someone's state of mind to intervene in a way that is not particularly humane, but is necessary. Developing a relationship is effective – but it's difficult when the person is in handcuffs. It is not really a solution, and it takes advantage of fear and stigma in the public mind.

Mr. Wilson commented that the two speakers have resurrected his hopes in some areas he thought no one was aware of.

Ms. Lee asked about how they handle acutely suicidal people. Mr. Fields responded that the only way in to the four acute diversion programs is through the psychiatric emergency room at San Francisco General. In his program, the lack of dissonance (that is, the familiar environment) allows communication to start, for dealing with the thoughts that are creating a desire to harm oneself.

Ms. Shaw explained the reference to the Bates Committee and categorical money.

Mr. Taylor answered Ms. Lee's question. In Momentum's public sector programs, it is about a third or more of the clients with suicidal history and ideation. In the private paying commercial side of the residential program, close to 80% of the people have serious suicidal attempts in their history. There are lots of reasons to avoid working with that population, but Momentum does not avoid it.

Ms. Bachand shared that La Selva had been instrumental in her recovery from a suicidal period.

Mr. Fields expressed a concern that because of the funding stream, suddenly crisis residential would become a magnet for people who hold none of the values that he had discussed.

#### **10. Violence & Mental Illness – Separating Fact From Fiction**

Dr. Nelson introduced Renee L. Binder, M.D., former Chair of Psychiatry at the UCSF Langlely-Porter Psychiatric Institute, and founder and director of the UCSF Psychiatry and the Law Program.

- Dr. Binder provided a historical perspective of the relationship of violence and mental illness. She provided quotes from Plato, Aristotle, and Benjamin Franklin.
- Dr. Binder had the Planning Council consider definitions of violence and mental illness.
- She referenced the MacArthur study in which patients discharged from an acute inpatient unit, whom they thought were going to be violent, were followed. Multiple sources of information were used to verify information, as well as arrest records, convictions, and hospital records.
- The people doing the MacArthur study also had to consider to whom they were comparing those with mental illness.
- In looking at implications of research, the factor of social stigma as well as the definition of violence and mental illness and the comparison groups must be considered.
- Research shows that persons with mental disorder account for only 3-5% of violence in the United States. That means that at least 95% of violent acts are committed by people without serious mental disorders.
- Statistics vary in how many of those incarcerated have mental illness. Here again the definition plays in. In general, it is 10-16%. About 5% have serious mental illness. 10% have significant psychiatric disability. People in the criminal justice system may have personality disorders, substance abuse issues, and antisocial personalities, but most do not have severe mental illness.
- To phrase the question the other way: do people with mental illness commit violence? The National Institute of Mental Health Epidemiologic Catchment Area Study was a good study because it involved almost 18,000 subjects in five communities who were studied for rates of psychiatric disorder. The study got data on violence for 7,000 subjects.
- Dr. Binder showed the results. Patients with serious mental illness – schizophrenia, major depression, bipolar disorder – were 2-3 times more likely as people without such an illness to be violent. Substance abuse raises the risk. The highest risk is when a major mental illness is combined with a substance-related disorder.

- The other excellent study, which comes out of the MacArthur group, is Violence by People Discharged from Acute Psychiatric Inpatient Facilities (again, compared to others who were in the same neighborhood). The prevalence of violence within one year after the hospital discharge for patients with major mental disorder was 18% for patients without alcohol/drug problems and 31% for patients with alcohol/drug problems.
- Dr. Binder showed research results of factors that modify the risk of violence with mental illness.
  - Situational factors modify other historical and clinical factors, such as gender, age, diagnosis, socioeconomic status, etc.
  - For people in a state of acute decompensation from a major mental illness, the incidence of violence between men and women equalizes.
  - Violence tends to decrease as people get older.
  - The most significant risk factor for every study ever undertaken is a history of violence.
  - The next most significant risk factor is alcohol/substance abuse; then an acute paranoid state of schizophrenia; non-compliance; and interpersonal relationships.
  - The most likely victim is a family member or caretaker.

## **11. Follow-Up Questions/Discussion**

Ms. Bachand asked about the idea of people being hard-wired for violence (i.e., Jeffery Dahmer). Dr. Binder responded that there are all sorts of people who have urges and impulse control disorders.

Ms. Collins asked if a person must have some form of mental illness or thought disorder to reach that level of violence. Dr. Binder replied that when she talks about mental illness, she means people with a diagnosable mental illness. People commit crimes for all sorts of reasons.

Mr. Wilson asked what is considered normal. Dr. Binder answered that it is often defined in terms of functioning. The line has to be drawn somewhere, especially when talking about risk and diagnoses. The question does not have a simple answer or a clear-cut delineation.

Ms. Abbott asked if severe personality disorders are in Dr. Binder's definition of mental illness; what is the least stigmatizing response? She responded that severe personality disorders can be associated with violence, but no more than anything else. The message we need to give is that people with mental illness are no more likely to be violent than other people. Substance abuse, particularly stimulants such as crack cocaine, is highly correlated.

Andi Murphy asked about any studies linking bullying with eventual violence. Dr. Binder replied that currently many people are interested in bullying, and the schools have very good anti-bullying campaigns.

Dr. Nelson expanded on that question, asking if there is any speculation looking at the kinds of social experiences that people with mental illness may be uniquely susceptible to, that might predict their small but significant difference of risk for violence. Dr. Binder felt that the issue is engaging people in treatment: trying to respect them and get them involved. She illustrated the idea by sharing the experience of a young man on the hospital unit who was at odds with his parents; all three needed to be in treatment.

Ms. Cease spoke about a student in Juvenile Hall who had shot five people; what interventions can be done when a young person is going into a gang? Dr. Binder replied that it is very difficult. There are some treatments that work better than others – multiple ways of intervening with the kids and family.

### **Laura's Law: Pro Viewpoint**

Ms. Nickerson introduced the topic of Laura's Law. The first speaker was Randall Hagar, Director of Government Relations, California Psychiatric Association. He spoke about why he believed the passage of the assisted outpatient treatment law to be important.

Mr. Hagar stated that while he was with the National Alliance on Mental Illness (NAMI), he had helped to write Laura's Law. He described the period of time for him from which Laura's Law had come. His son had been very ill at a very early age, and by the time he was 15 he had a psychotic episode. Mr. Hagar found how difficult it was to get him admitted with the treatment laws then in place.

Laura's Law came about as a means to address a very small but significant population that was refusing treatment. A study at Duke University in 1999 at the assisted outpatient program studied three populations: those who had a court order only, those who had intensive services only, and those who had a combination of the two. The finding was that people who benefit most are those in the latter group.

Mr. Hagar and his colleagues used that concept to address the 23.7% dropout rate in California's AB 2034 program. They used Kendra's Law as a template for Laura's Law.

The best way to understand Laura's Law is that it provides court-supervised intensive services. It is designed to reach people who are having grave difficulty engaging in even the 24/7 wraparound services.

Today, up to 200,000 people get their outpatient services in a jail setting. The issue that crystallizes why these programs are important is that even when people don't recognize their illness (called *anosognosia*), many of them can still be coaxed into treatment to their benefit. However, data demonstrates a small group of people who refuse – and that is what Laura's Law is about. It is tool in this Assisted Outpatient Treatment (AOT) that is an effective model for recovery for some people.

Mr. Hagar shared some points that had struck him about the Nevada County program. It is possible to use a level of coercion that is less than institutionalization – it is a process where even if people have to go to court, they go home afterwards to their families and friends.

### **Questions**

Ms. Lee asked if those appointed by the court to make sure that these people come in resent having extra duties. Mr. Hagar replied that a program has been set up in Nevada County to provide a liaison with the court and the services.

Ms. Cedro-Hament said that in L.A. County, she has parents who push for the “full implementation” of Laura’s Law. She asked what that meant. Mr. Hagar explained that L.A. County from the beginning has chosen to use the voluntary settlement option.

### **Laura’s Law: Con Viewpoint**

Ms. Nickerson introduced Eduardo Vega, a former MHSOAC Commissioner. He is now the Executive Director of the Mental Health Association of San Francisco. He provided a different perspective of Laura’s Law.

Mr. Vega stated that he also represented California Mental Health Peer-Run Organizations (CAMHPRO).

He believed that involuntary processes, coercion, and non-consensual incarceration, whether through judicial order or hospital institutionalization, should be a part of our past. In our journey to provide respectful, supportive, effective services for people with mental illness, we have a big role to play in moving the future forward and pushing changes that we have experienced – including recovery/transformation – across the world to bring dignity and health to many, many people.

The California Memorial Project recognizes the tens of thousands of people who died and were buried in unmarked graves in Napa and other state hospitals.

The new Center for Dignity Recovery and Stigma Elimination is a statewide program that brings technical supports, best practices research, and effective program implementation through training and technical assistance across California. In the eyes of people with lived experience, dignity seems to be one of the things historically overlooked.

Mr. Vega gave a historical background on the movement to end “inappropriate, involuntary, and indefinite commitment of mentally disordered persons.”

He clarified the Nevada County program happening under the context of Laura’s Law from the practice of involuntary outpatient commitment.

In general, advocates fueled by anger, grief, and pain are the forces that have made positive change in the mental health system. Great legislative programs like AB 34 and AB 2034 set the stage for what became the Mental Health Services Act (MHSA) and some of the most progressive services and supports in the history of the country.

However, Mr. Vega felt that Laura’s Law was the result of someone working from a personal community trauma trying to create a systematic support. His argument was that what we do now through the MHSA and full-service partnerships can achieve at least as much as any program to change this involuntary outpatient process. It is actually more in the spirit of programs we want to be doing in California, and will lead to better outcomes overall.

Even at the national level there is much division over Laura’s Law among family advocates, and certainly within the provider community.

The American Psychological Association does not take a stand on involuntary outpatient commitment, but they frame out the concerns in an effective way which Mr. Vega provided to the Planning Council.

For several reasons, a lot of national mental health organizations – particularly those focused on mental health rights and progress – oppose involuntary outpatient commitment. These include Mental Health America.

The California Council of Community Mental Health Agencies (CCCMHA), which represents the vast majority of community-based providers, has taken a position against involuntary outpatient commitment.

Mr. Vega shared his personal history to illustrate that engaging with people in a positive way, and having good conversations about what they want, can make a difference.

He pointed out differences in involuntary outpatient commitment between a small county such as Nevada County and a large county such as San Francisco County.

Mr. Vega explained that more processes that involve authorities coming in and telling people what has to happen in their lives, and threatening recourse, is the wrong direction. All that we have been doing in California to build recovery-based supports, to practice positive engagement with people, and to support their journey in recovery, stands to be counteracted through these types of programs.

## **Questions**

Ms. Cedro-Hament asked if the CMHPC had taken a stand on Laura's Law a few years ago. Ms. Nickerson replied that the Planning Council had talked about it, but did not have the same information that they had received today. Ms. Shaw stated that at the time of the original legislation the CMHPC had taken a position opposing Laura's Law.

Ms. Mitchell mentioned that she had had great difficulty with some of the tactics of the Treatment Advocacy Coalition (TAC). Mr. Hagar stated that he was the cofounder of TAC; it had been developed to support AB 1421 – Laura's Law. He was not aware of any data showing that TAC's tactic of identifying violent acts in the media contributed to a rise in nimbyism.

## **12. Public Comment**

Ms. Flores commented that she had appreciated hearing both sides. Ms. Abbott agreed.

Ms. Cease stated that as a family member, she was definitely for people receiving the right kind of treatment, even if they don't like it.

Ms. Lee ascertained that today's discussion was informational – the Planning Council was not going to take a stand or vote.

Ms. Lewis noted that the Planning Council's existing position predates some of the newer members who had not had the chance to weigh in.

Mr. Vega pointed out that the presentation on the reduction of costs in the Nevada County programs was based on data from 17 individuals only. Only four of those were actually under involuntary outpatient commitment. He felt that this illustrated that the

right kind of engagement, services, and supports do work; but the threat of coercion to bring those about is not the right kind of structure.

### **13. New Business**

Executive Officer Adcock announced that the Bureau of State Audits would be releasing its draft report on June 27; comments would be due on July 3. The conference call was rescheduled for July 2. The release date for the final report had been adjusted to July 30.

In response to a comment from Ms. Black about the difficulty of reading the PowerPoint presentations on the screen, Executive Officer Adcock stated that all meeting PowerPoints would be posted on the website within a week or so after the meeting.

Dr. Nelson commented that the SAMHSA presentation had been incredibly dense with information.

Ms. Hart remarked that not all Planning Council members have color printers at home for printing the PowerPoints. She also remarked that she liked to make notes on the PowerPoints during presentations.

Executive Officer Adcock directed the Planning Council members to some documents inside the packets and explained them:

- An overlay of mental health funding by fiscal year with funding sources
- A flowchart of legislative bills; accomplishments through 2011
- Accomplishments of 2012-13
- State and federal mandates
- Two documents depicting what's contained in the state budget

## **Friday, June 21, 2013**

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

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

### **2. Opening Remarks**

Chair Wilson welcomed Patrick Miles, Assistant Director, San Mateo County Department of Behavioral Health. He spoke about Community Service Areas (CSAs), a successful organizational structure used in San Mateo County.

CSAs had been influenced in their creation by a SAMHSA article that explained that a good, modern mental health and addiction system needed to meet the challenges of the new health care reform law, which recognizes that prevention, early intervention, and treatment of mental health and substance use disorders are integral parts of improving and maintaining overall health. There is a key role for behavioral health services in overall health.

The article recognized the tremendous health challenges that consumers face.

Mr. Miles described the overall organizational structure that the county is working to develop to implement CSAs.

- They emphasize how consumers are embedded in families, who have a tremendous role to play in recovery.
- The system is embedded within a community which should be able to enter the system in any of four areas: prevention, early intervention, treatment, and recovery.
- As needs change for individuals in the system, they should be able to transition easily to other parts of the system. Clients with symptoms that have stabilized should be able to transition to recovery environments where their needs are better served and addressed.
- Management of the CSA is performed by one manager and a planning council. The planning council is comprised of a 51% majority of consumers and family members as well as contract agencies, providers in the community, public agencies, advocacy groups, and primary care.

#### Guiding Principles

- In building CSAs, the county is centering their work on communities and integrating that work with primary care.
- Wherever possible, they will be co-locating mental health and substance abuse services in the same area.
- They will be ensuring prompt access to care by implementing same-day access to their system.
- They will embrace consumers and families at all levels of the system. They will include peer and family support greeters and mentors to help clients navigate services.
- Treatment must be coordinated across traditional silos.
- Hours of service and entry points need to be flexible.

The county is using the Lean Quality Management Process developed under Toyota. A primary emphasis is that quality is everyone's job. The county has been implementing week-long planning events that bring together providers, contractors, stakeholders, family members, schools, police, child welfare, and other stakeholders to help initiate the plans.

A key emphasis in the Lean Quality Management Process is being able to measure outcomes.

- The county has purchased an electronic analysis data system called Enlighten Analytics. Managers and others will be able to get key information any day of the week.

- A performance monitoring workgroup is developing key quality indicators for their system.

## Questions

Ms. Cedro-Hament asked about the integration of spirituality; where is the faith-based organization in the structure? Mr. Miles replied that it has a higher profile in the system than it did a few years ago. It could be spelled out and indicated more in the CSAs.

Ms. Hart queried how many physical areas there are. Mr. Miles responded that there are five areas with a sixth to be created.

Ms. Abbott asked about spelling: the terms are *Lean Quality Management Process* and *Enlighten Analytics*.

Executive Director Adcock asked if the CSAs were an effort to comingle health services and mental health in anticipation of health care reform. Mr. Miles said that it was. An example of a successful health promotion activity in the county had been smoking cessation since then they had expanded with nutrition programs. They have many partners in their overall health system that they work with on health promotion.

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

Cary Martin, President of CALMHB, stated that as of now CALMHB has no staff. He desired for CMHPC to own some of the reasons that poor and crippling support is a problem.

He clarified his message of the previous meeting: he has always believed that State Senator Marks' intent was to save the last half of mental hygiene, and he believed that is precisely what Senator Marks did. That is why we all should honor him.

Mr. Martin listed reasons that CALMHB needs comparable state-of-the-art support, by providing California Welfare and Institutions Code Section 5601 and its components. He had highlighted portions of 5604.2 to call the Planning Council members' attention to the meat of the code.

Mr. Martin noted that he had begun reporting to the Planning Council before the number of U.S. casualties in Iraq and Afghanistan had reached 300. He attributed the state outreach to veterans program called Military 101 to the CMHPC.

So many veterans returning to the state of California have PTSD. Mr. Martin illustrated how the numbers and roles for women are increasing in the military. He hoped that proactive preparation for those who return will not require another Walter Reed.

Mr. Martin stated that CALMHB has called attention to the increasing numbers of women in the penal system. As with men, many violations have a mental health/substance abuse component. Unlike men, women are not yet epidemic.

Mr. Martin invited the Planning Council members to hear the speakers at the CALMHB meeting that afternoon.

He requested recognition for Walter Shwe, who has served the people of California on both CMHPC and CALMHB. The Planning Council members responded in applause. Mr. Martin presented a Certificate of Appreciation to Mr. Shwe in recognition and gratitude for his service and dedication as the CMHPC liaison to CALMHB. Executive Director Adcock also thanked Mr. Shwe for his long years of service.

### **Questions**

Ms. Cedro-Hament asked if the MHSOAC was giving money to CALMHB. Mr. Martin responded that they have a small contract, but no dollars are flowing as yet. There is verbal support, and the door is cracked open. They need sufficient support for their people to be able to carry out their mandate, which is all-encompassing for every citizen of the state.

Ms. Cedro-Hament also asked the San Mateo Mental Health Board where they were with regard to Behavioral Health and Recovery Services; Sharon Roth answered that people on the board are co-chairs on every committee that the county has. They were very involved in the restructuring.

Dr. Nelson asked about the Planning Council's possible culpability in CALMHB's legal charges not being pursued. Mr. Martin assured Dr. Nelson that he credits the Planning Council for what they have done; he looks forward to collaborating with them in ways that they have not exercised their powers. The Planning Council does not provide financial support for the boards and commissions in any fashion. That was what Mr. Martin was referring to as so lacking – the kind of support that allows the CALMHB Board to perform its job of supporting the county boards and commissions across the state.

Ms. Lee asked if there had been any movement since the last meeting to provide staff and financing for CALMHB. Mr. Martin said that there had been no change. He was hopeful that the afternoon meeting might change that.

Ms. Lewis agreed with the prior comments. She stated that the CALMHB Board predated the OAC and the Planning Council and had its mandates to fulfill. Had it not been for the existence of these community organizations, we would never have had Proposition 63 and groups like the National Association of the Mentally Ill.

Ms. Lewis stated that in L.A. County, partnership and visibility have to be within the communication devices. That is the one way for people to understand the importance of the CALMHB Board and the organization of Mental Health Advisory Boards/Commissions countywide. She continued that with the transfer of funds to the local level, she believed that the power to get this done lies at the local level. The organization of Mental Health Advisory Boards/Commissions must be part of the plan to put the staff there. The Boards of Supervisors have lacked that responsibility for many years, to the point that they do not appoint to the areas they should.

Ms. Abbott asked why CMHPC does not have someone from the Department of Healthcare Services. Executive Director Adcock stated that Vanessa Baird has been clear that the Mental Health Director for that section will be a Planning Council member – that will be Brenda Grealish who is commencing her duties in October.

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

Chair Wilson stated that Dr. Rollin Ives, Special Advisor, Mental Health and Substance Use Disorder Division, Department of Health Care Services, was not present.

#### **5. Report from California Mental Health Directors Association**

Chair Wilson thanked Pat Ryan, Executive Director of the California Mental Health Directors Association, for her service as she is soon to retire. Ms. Ryan updated the Planning Council on key activities of CMHDA.

- The state budget had ended up protecting the 1991 Realignment revenue source; the Legislature had been very supportive of it. This victory may result in about \$35 million of savings in the next budget year, and significantly more in subsequent budget years.
- Accordingly, CMHDA was able to remind people that the community mental health system has lost about \$700 million over the past decade or so as a result of the downturn in the economy.
- As part of the budget process this year, the state is in the process of implementing the Affordable Care Act (ACA) and Medicaid expansion.
- A new Senate Mental Health Caucus has been formed, chaired by Senator Jim Beall. He has injected much energy and focus on mental health issues in the Legislature. Because of his leadership and that of Senator Steinberg, there is an increasing understanding and appreciation for community mental health issues in the Legislature.
- In January 2014, mental health benefits for both the expansion population and the current MediCal population will include expanded benefits under health plans for mental health services that will cover group therapy and individual therapy at parity (meaning no arbitrary limits for those benefits). The two populations will still have access to the current array of benefits available under the MediCal specialty mental health program that counties administer.
- Senator Steinberg convinced both the Governor and the Legislature to approve an additional \$204 million for the Mental Health Wellness Act.
  - We have a one-time injection of \$142 million into the community mental health system to help build an infrastructure that will improve our community crisis response.
  - The MHSOAC has been given the responsibility under the Mental Health Wellness Act to administer the grants for 600 community triage workers. This is to help people navigate the health care system between health and mental health, and to serve individual needs of clients at the local level.

#### **Questions**

Ms. Abbott asked if the Planning Council should send Senator Beall a thank-you letter. She also asked whether the CMHDA has any concerns about health care reform. Ms.

Ryan responded that there had been concerns over the gaps in services for mental health in the fee-for-service system and in substance use. The state has now added a few new benefits under mental health, to be administered by health plans. Specialty mental health plans will continue to be administered by county mental health plans.

Ms. Ryan continued that the other concern is how well county mental health plans will work with health plans in the coordination of services; we do continue to have a “carve-out” between specialty mental health and overall health care.

Ms. Abbott asked Ms. Ryan to expand on the California Health Facilities Financing Authority. She explained that Senator Steinberg’s office did not feel that the Department of Health Care Services had the capacity at this point to administer the program. The California Health Facilities Financing Authority will use a one-time, short-term grant process, organized to provide grants to help local communities to build infrastructure and capacity.

Mr. Robinson felt that the huge gains this legislative year had been due in very large part to Ms. Ryan’s leadership and the CMHDA. He was most pleased and impressed by the CMHDA’s work to engage community providers. Ms. Ryan responded that CMHDA County Mental Health Directors can’t and shouldn’t protect the community mental health system on their own – it needs to be a joint effort with the state Legislature.

Ms. Lee asked if the CMHDA could help with the CALMHB Board’s problems. Ms. Ryan replied that she needed to know more about it, and would bring back the comments to her organization.

Ms. Shaw asked about the \$300 million “take back.” Ms. Ryan explained that in the overall budget deal between the counties and the Legislature/Administration, the Brown Administration was adamant that counties will be saving money as a result of the implementation of Medicaid expansion. Therefore they wanted counties to be sending money back to the state. The counties made the argument that there won’t be a cost to the state from implementation of Medicaid expansion for another three years; they want the money now. CMHDA wanted to wait and see what the savings actually are, and it needs to be on a county-by-county basis. The Legislature had some budget priorities; they cut a deal to go with the \$300 million in the first year.

Ms. Mitchell commented that she had not seen the California Health Facilities Financing Authority ever have a grant program, but only low-interest loan programs. Ms. Ryan stated that the legislation said that it would indeed be a grant. They will want to see counties working with community partners to leverage other funds.

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

Chair Wilson introduced Ms. Sherri Gauger, Executive Director of the MHSOAC, who presented an update on the activities underway at the Commission. She also spoke of opportunities in the near future for the Commission and the Planning Council to work together, to implement some of the provisions of the statewide Evaluation Master Plan.

- The Commission had learned just a few weeks ago of Senator Steinberg’s idea to house some of the Act’s responsibilities with the Commission. They are hurrying to prepare.
- A few new Commissioners have come on board. There is now just one vacant seat, for Labor Commissioner.
  - The Governor appointed Dave Gordon to the School District Superintendent Seat.
  - Dr. Paul Keith has been appointed to the Health Plan Provider seat.
  - Lee Ann Mulell has been appointed to the Family Member with a Child set (vacant for quite some time).
  - Khatera Aslami has been appointed to the seat vacated by Eduardo Vega.
  - John Buck has been appointed to the Small Business seat.
  - Reappointed Commissioners were Sheriff Bill Brown, Dr. Larry Poaster, Dr. David Pating, and Tina Wooton.
- Regarding evaluation efforts: The Commission approved a statewide Evaluation Master Plan and a Five-Year Implementation Plan. They have entered into two contracts that start new activities for the first year of the Implementation Plan, with CiMH and Mental Health Data Alliance.
- One of the major goals of the Evaluation Master Plan is to develop a Continuance Performance Monitoring System. The statute has a role for the Planning Council in those types of efforts; the MHSOAC will be requesting continuous collaboration.
- The Evaluation Master Plan also outlines several steps for the next five years. Ms. Gauger said that the Commission and the Planning Council can work together on the following.
  - The Plan should continuously refine the measurement of existing indicators.
  - The Plan recommends working with the Planning Council to decide on adding or dropping indicators.
  - There are many efforts going on throughout the state to develop indicators and systemwide performance monitoring. The Department of Health Care Services is developing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) performance measures; the Commission wants to work with them in this process.
  - The Commission wants to look at developing indicators that go beyond Community Support Services (CSS) – Prevention and Early Intervention, innovation of WET, etc.

- The Commission wants to look at incorporating other community and general indicators that may be out there.
- Possibly Dr. Bradley could come and speak to either one of the workgroups working on the datasets, or even speak to the full Planning Council on getting down to specifics – how can the two groups start working together on the key indicators?

## **Questions**

Ms. Hart inquired as to whether the Client Stakeholder Project would go only to the client group that received the grant, or if it would go out from the family perspective. Ms. Gauger stated that the funding was transferred to the Commission from the Department of Mental Health. It used to be a contract for the network. She continued that the new client contract requires a community planning process evaluation; they are expected to reach out to families and communities, and also to reach out to NAMI, the California Youth Empowerment Network (CAYEN), and United Advocates for Children and Families (UACF), and the Mental Health Board Association.

Ms. Cedro-Hament underlined the role of the CALMHB Board, as well as the Planning Council, in the planning. Ms. Gauger noted that she had met with the CALMHB Board in January and was very much aware of the lack of funding. She and Ms. Norma Pate, MHSOAC's Administrative Chief, were meeting with the CALMHB Board that afternoon.

## **7. Council Member Open Discussion**

Chair Wilson announced that the topic would be how to better serve the consumer voice on the Planning Council.

Ms. Cedro-Hament commented that some terms and acronyms that Planning Council members use are confusing to new members and consumers. She suggested having some time after the General Meeting for them to talk about their reactions to the meeting.

Ms. Lee mentioned that during the last year, the emphasis has been on children and youth. Older adults have been ignored and this should change. Secondly, during past Planning Council meetings, Chair John Ryan would have the members add a little personal information during the introductions to help the new members blend in.

Ms. Thal suggested that when we bring in presenters and committee chairs, that we ask them to be careful about using acronyms. She added that the afternoon mentorship was a vehicle for preparing up and coming leaders.

Ms. Lewis thanked the sound engineer and Michael Dorman – they do their jobs well and it helps the entire Planning Council. Regarding the consumers, Ms. Lewis suggested for the consumers to attend committee meetings to make their voices heard. Another suggestion would be to prepare the presenters beforehand with specific questions that the Planning Council would like them to address.

Mr. Wilson agreed that acronyms in PowerPoints need to be spelled out. He also gave kudos to the sound engineer – the sound and microphones had been perfect during the meeting (and the red light was helpful).

Ms. Abbott commented that the acronym problem comes up all the time. There is a hesitancy to interrupt the speaker. Maybe the members could use placards that say “*Acronym*” to hold up for speakers to see.

For new members, Executive Director Adcock suggested having a conference call one week before the meetings to go over the contents of the packet. Then a week after the meeting, there could be a debriefing call. Members reacted positively and Executive Director Adcock committed to scheduling these meetings.

Ms. Shaw suggested having a list of acronyms available on the website.

Ms. Thal ascertained with Executive Director Adcock that all conference calls are noticed in order to fulfill the spirit of the Bagley-Keene Act.

Ms. Lee applauded Ms. Nickerson for arranging the dinners during the Planning Council meetings.

Ms. Hart felt that mentors carry a major role. Perhaps they should belong to the same committees as the mentees. Also, perhaps mentors could make phone calls before and after the meetings to their mentees. Executive Director Adcock confirmed that the mentors and mentees do belong to the same committees.

Mr. Wilson offered an idea of Chair Wilson’s to include lists of acronyms in the meeting packets.

Ms. Abbott requested to list the Children’s Caucus at the end of the Wednesday session.

Ms. Cedro-Hament observed that some of the consumer members are quiet during the meetings; she would like to hear their point of view.

Ms. Bachand had noticed that the consumers are speaking up more. She also offered a public apology to Ms. Lee.

Ms. Lee responded that it takes awhile to feel included – that doesn’t happen the first or second time a new person attends a meeting.

## **8. Public Comment**

John Sturm, Chair of the San Diego Mental Health Board, had made copies for the Planning Council of the In Home Outreach Team (IHOT) Program Report as promised. He also addressed the problem of people with mental illness being demonized. Statistics show that those who are severely mentally ill are far more likely to be hurt by someone else than to hurt someone.

Frank Topping of Sacramento County shared an experience with WET funding. He attended regional training where they were instructed that WET funding was clearly able to support partners including law enforcement. He then attended a workgroup where the director of the MHSA program made the statement that law enforcement could not be included in any way; the director subsequently corrected that statement. Mr. Topping

voiced agreement with Cary Martin that the Association does provide benefit and does warrant support.

Sharon Roth of San Mateo County stated that they will be holding a California CIT conference in San Mateo in January 2014. The conference will be for law enforcement, mental health professionals, family members, and consumers. She invited the Planning Council to attend.

Ms. Lee inquired about Personal Services Coordinators for IHOT. Executive Director Adcock replied that in other counties, it is the staff person who works with individuals that are in a Full Service Partnership. She added that IHOT is a pilot program. Mr. Sturm concurred with both statements.

Ms. Cease asked what CIT stands for; Ms. Roth replied that it is Crisis Intervention Training, and that it is usually involved with law enforcement.

Ms. Hunter asked about the charge for the CIT training. Ms. Roth replied that it will probably be \$100 for the two days including lunch. Consumer scholarships will be available.

Ms. Nickerson hoped that the Planning Council would send people to some of these trainings as they had done in the past.

## **9. New Business**

Mr. Robinson thanked the Advocacy Committee for their work in coordinating yesterday's sessions. He continued that he was unclear about the structure of the opportunities to work with the OAC regarding the CALMHB Board. He added that there is still considerable work to be done on Senator Steinberg's Mental Health Wellness package to ensure that the programs are in line with crisis residential programs.

Executive Director Adcock responded that historically, the Department of Mental Health provided a very lean amount of funding for the Association to operate. That small contract has transferred to the MHSOAC. In addition, the CALMHB Board's funding had shifted to the MHSA in recent years.

She continued that when she came on board at the Planning Council, she met with Mr. Martin who made clear that the CALMHB Board needed clerical support and more dollars to handle administrative functions. The state bureaucratic process to request funding, the Budget Change Proposal, is very complicated and takes about a year. The OAC has commenced conversations with Mr. Martin's team. In the meantime, Ms. Gauger has obligated some of her staff to help with some of the CALMHB Board's administrative functions. Additionally, the OAC has some unobligated contract dollars that they have obligated to the CALMHB Board with the function to work with the Peers contract on the stakeholder piece.

Executive Director Adcock continued that as she rents the hotel spaces for Planning Council meetings, she schedules the half day Friday for the CALMHB Board at no extra cost to them or to the Planning Council.

Mr. Robinson requested an update on the situation at the next Planning Council meeting.

Ms. Lewis inquired as to whether Mr. Robinson's request requires a motion to make it official; Executive Director Adcock responded that it did not. She had made a note to put it on the agenda. Ms. Lewis volunteered to attend the CALMHB Board's Saturday session and to be a backup for Susan Wilson, the new CALMHB Board liaison.

Ms. Nickerson noted that as the SAMHSA grant is due at the beginning of September, the Planning Council will need to be working on it in between meetings to meet its federal requirements. Executive Director Adcock noted that the Planning Council members would be receiving a number of emails in the next few months.

Ms. Shaw noted that the Planning Council has a mandate to review and approve performance outcome measures. She requested clarification on the Planning Council's role, as the OAC has received a large amount of funding to do the evaluation.

Executive Director Adcock responded that for several months, Chair Ryan had made multiple attempts to meet with them to have that very conversation. The OAC had cancelled and declined. Recently their Research Scientist had reached out to Linda Dickerson and Executive Director Adcock. She saw a time in the near future when the Planning Council would be sitting down with the OAC to get more concrete about operationalizing the collaboration.

Ms. Hart commented that the members of the Continuous Systems Improvement Committee had received a copy of the Evaluation Plan. She noted that she had applied to be on the OAC's Evaluation Committee but had not been accepted.

Ms. Dickerson relayed that the OAC's Evaluation Committee always allows individuals to attend who are not on the committee.

## **10. Meeting Highlights**

Chair Wilson stated on behalf of herself and the Executive Committee that the Planning Council members themselves are the highlights.

- The feedback that the Planning Council members had provided to OSHPD for the MHSA focus group questions was phenomenal and will make a huge difference.
- An Ad Hoc Committee was established to review the state budget audit.
- Chair Wilson acknowledged all the committees, particularly the Advocacy Committee, for all their hard work. The presentations had been great.

## **11. ADJOURN**

Chair Wilson adjourned the meeting at 11:50 a.m.

X INFORMATION

TAB SECTION: C

\_\_\_ ACTION REQUIRED:

DATE OF MEETING: 10/17/13

PREPARED BY: Michael Gardner

DATE MATERIAL  
PREPARED: 9/18/13

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AGENDA ITEM: California State Auditor Report 2012-122, August 2013

ENCLOSURES: • Pages 38- 42 of the report; CMHPC response to the report page 141

OTHER MATERIAL RELATED TO ITEM: <http://www.bsa.ca.gov/pdfs/reports/2012-122.pdf>

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**ISSUE:**

The California State Auditor released a report in August 2013 on the effectiveness of the Mental Health Service Act. The California Mental Health Planning Council was mentioned in the report and those pages have been extracted and are attached. The entire 157 page report can be accessed through this link. <http://www.bsa.ca.gov/pdfs/reports/2012-122.pdf>



### ***The Planning Council Has Not Fulfilled Its MHSAs Responsibility***

Finally, state law requires a third entity—the Planning Council—to annually “review the performance of mental health programs based on performance outcome data and other reports,” and state law

makes it clear that MHSAs programs must be included. (The text box describes the Planning Council.) However, despite receiving MHSAs funding to perform evaluations, the Planning Council has yet to fulfill its MHSAs responsibilities. For its fiscal year 2011–12 operations—as depicted in Table 3 on page 30—the Planning Council reported a budget of \$791,000, and MHSAs funds made up roughly 60 percent of that. When asked how the Planning Council fulfilled its MHSAs requirement, the executive officer pointed us to a report titled *California Mental Health Planning Council Accomplishments, 2008–2010* (accomplishments report). For the section applicable to the MHSAs, the accomplishments report cites a Mental Health Board Workbook Project (workbook) and describes the workbook as a tool to facilitate uniform reporting to the Planning Council by local mental health boards on their analyses of their local performance data. However, the accomplishments report did not indicate whether any data collection or evaluations occurred.

#### **California Mental Health Planning Council**

The California Mental Health Planning Council (Planning Council) comprises 40 members whose purpose is to advocate for individuals with serious mental illness, to provide oversight and accountability for the public mental health system, to advise the governor and the Legislature on priority issues, and to participate in statewide planning. At the end of June 2012, state law transferred responsibilities relating to the Planning Council from the California Department of Mental Health to the California Department of Health Care Services (Health Care Services). The Planning Council, according to the Health Care Services Web site, holds quarterly meetings in different sections of California to allow maximum participation. Membership must include eight representatives from various state departments and appointees from various mental health constituency organizations. State law requires at least one-half of the members to be persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities.

Sources: California Welfare and Institutions Code, meeting minutes provided by the Planning Council, and Health Care Services' Web site.

The Planning Council's executive officer attributed the workbook to her predecessor, stating that there are no associated records of what was done with the workbook or any county

submissions based on the workbook, but that the Planning Council was in the process of designing a new workbook in consultation with county mental health boards. She also provided a draft revision of the accomplishments report extending through fiscal year 2012–13. However, the draft accomplishments report did not include actions satisfying the Planning Council's responsibilities related to the MHSAs. Members of the Planning Council stated that the Planning Council reviewed the performance of certain MHSAs programs by receiving information counties submitted and through presentations and other materials. However, because it did not document the results of its review of this information, we question whether the Planning Council met its statutory responsibility in this area. The executive officer stated that the Planning Council does not have resources to perform raw data analysis and until very recently there were almost no reports on MHSAs programs, creating a lack of material with which to work. Reviewing the performance

of MHSA programs is critical to determining whether the MHSA is fulfilling its stated intents and purposes, yet the Planning Council, like the other entities charged with evaluating these programs, is not fulfilling its responsibility.

### Counties' MHSA Funding Allocations May Not Be Appropriate

Another area of concern is the methodology used to determine the factors governing the MHSA funding to allocate to counties. A lack of substantive updates to the factors calls into question the propriety of the methodology. Mental Health was tasked with creating a method to divide among the counties annual tax revenues remitted to the Fund. Available documentation shows that Mental Health's methodology identified several factors and weighted them to derive each county's share (see text box). Mental Health outlined that methodology in a document issued to counties in June 2005. According to a Health Care Services memorandum, Mental Health last applied the methodology in fiscal year 2009–10. In subsequent years through fiscal year 2012–13, allocations were based on the ratio of the county's allocation to the total allocation for all counties for fiscal year 2009–10. However, it appears Mental Health has not updated the factors since 2008 and therefore has not accounted for counties' prevalence of mental illnesses, poverty rates, or populations. Thus, a county with a sharp rise in the prevalence of mental illnesses may still receive the same proportion of MHSA funds that it did for fiscal year 2009–10. Of further concern, based on available documentation, Mental Health developed its methodology in 2005, at the time that it implemented the Community Supports component, and does not appear to have altered that methodology when it implemented the remaining four components. Consequently, to the extent that changes such as in county population or the introduction of new MHSA components warrants modification of the allocation formula, MHSA allocations to counties may not be appropriate to meet changing county needs.

During the course of our audit, we made repeated requests of Health Care Services for documents and information regarding the allocation methodology, but its officials did not comply with our requests.

At our audit closing conference in mid-June 2013,

#### Summary of Factors the California Department of Mental Health Included in the Mental Health Services Act Allocation Methodology

State law required the California Department of Mental Health (Mental Health) to divide the available amount of Mental Health Services Act funds among the counties for any particular year and to give greater weight to significantly underserved counties or populations. Mental Health developed a formula, including the following weighted factors:

1. The need for mental health services in each county based on the following:
  - a. The county's total population.
  - b. Population most likely to apply for services, which represents the sum of:
    - The poverty population.
    - The uninsured population.
    - Population most likely to access services, which represents the prevalence of mental illness among different age groups and ethnic populations of poverty households.
2. Adjustments to the need for mental health services in each county based on the following:
  - a. The cost of being self-sufficient.
  - b. The available resources provided in fiscal year 2004–05, such as funding sources, including the State's General Fund managed care allocations.
3. An additional minimum planning estimate for each county, to provide small counties with a base level of funding.

Sources: Welfare and Institutions Code and Mental Health's Letter No. 05-02, issued June 1, 2005.

Health Care Services officials in attendance again indicated that there was no such documentation. However, Health Care Services did provide a copy of a letter sent to the California Department of Finance dated June 2012 outlining how the factors comprising the methodology were weighted and applied to compute the counties' MHPA allocations for fiscal years 2009–10 through 2012–13.

Although the director has stated that Health Care Services will revise its methodology, currently no changes are planned until MHPA funding exceeds peak levels, i.e., the highest amount of taxes remitted to the fund in a single year, which occurred in fiscal year 2009–10, to ensure that adjustments to the methodology that might lower the amount a particular county receives will not result in a county being unable to fund existing MHPA obligations. The director stated that Health Care Services intends to review the existing factors to determine how updating them would affect MHPA allocations. Because responsibility for developing an allocation methodology now resides with Health Care Services, we believe it is imperative that it either update Mental Health's allocation methodology as necessary or create a new allocation methodology altogether to ensure that counties' MHPA allocations are appropriate and reasonable. Until Health Care Services can fully support the reasonableness of the allocation methodology, questions will remain as to whether the counties' allocations are commensurate with their need for mental health services.

## **Recommendations**

### ***Legislature***

To ensure that Health Care Services can withhold MHPA funds from counties that fail to comply with MHPA requirements, the Legislature should enact legislation that clarifies Health Care Services' statutory authority to direct the State Controller's Office to withhold such funds from a noncompliant county.

### ***Health Care Services***

To ensure that it monitors counties to the fullest extent as the MHPA specifies and that it implements best practices, Health Care Services should do the following:

- Draft and enter into a performance contract with each county that contains sufficient assurances for effective oversight and furthers the intent of the MHPA, including demonstration that each of the county's MHPA programs are meeting the MHPA's intent.

- Conduct comprehensive on-site reviews of county MHSA programs, including verifying county compliance with MHSA requirements.

To ensure that counties have the needed guidance to implement and evaluate their MHSA programs, Health Care Services should do the following:

- Coordinate with the Accountability Commission and issue guidance or regulations, as appropriate, for Facilities programs and for other MHSA requirements, such as a prudent reserve.
- Commence this regulatory process no later than January 2014.
- Collaborate with the Accountability Commission to develop and issue guidance or regulations, as appropriate, to counties on how to effectively evaluate and report on the performance of their MHSA programs.

To ensure that Health Care Services and other state entities can evaluate MHSA programs and assist the Accountability Commission in its efforts, Health Care Services should do the following:

- Collect complete and relevant MHSA data from the counties.
- Resolve all known technical issues with the partnership and client services systems and provide adequate and expert resources to manage the systems going forward.

Health Care Services should, as soon as is feasible, revise or create a reasonable and justifiable allocation methodology to ensure that counties are appropriately funded based on their identified needs for mental health services. Health Care Services should ensure that it reviews the methodology regularly and updates it as necessary so that the factors and their weighting are appropriate.

### ***Accountability Commission***

To ensure that counties have needed guidance to implement and evaluate MHSA programs, the Accountability Commission should do the following:

- Issue regulations, as appropriate, for Prevention and Innovation programs.
- Commence the regulatory process no later than January 2014.

To fulfill its charge to evaluate MHSAs programs, the Accountability Commission should undertake the evaluations specified in its implementation plan.

To ensure that it can fulfill its evaluation responsibilities, the Accountability Commission should examine its prioritization of resources as it pertains to performing all necessary evaluations.

To report on the progress of MHSAs programs and support continuous improvement, the Accountability Commission should fully use the results of its evaluations to demonstrate to taxpayers and counties the successes and challenges of these programs.

### ***Planning Council***

The Planning Council should do the following:

- Take steps to ensure that it annually reviews the overall effectiveness of MHSAs programs in accordance with state law.
- Document and make public the reviews that it performs of MHSAs programs to demonstrate that it is performing all required reviews.



CHAIRPERSON  
John Ryan

EXECUTIVE OFFICER  
Jane Adcock

July 17, 2013

Elaine M. Howle, CPA  
California State Auditor  
555 Capitol Mall, Suite 300  
Sacramento, CA 95814

Dear Ms. Howle,

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

The California Mental Health Planning Council respectfully submits the following comment in response to the draft report for the audit of the Mental Health Services Act.

The Council agrees with and is taking steps to address the recommendations. As the report has acknowledged, there are insufficient sources of performance outcomes or other data available for the Council's evaluation. Until they become available, the Council will seek alternative, innovative ways to fulfill its statutory responsibility while maintaining its advocacy efforts and identification of successful practices.

Also, it should be noted that while the Council has not recently produced reports on performance outcomes related to the MHSA, the Council did develop and release the Performance Indicators in 2010 which have been subsequently adopted by the MHSOAC and are currently being used in their data analysis and evaluation activities.

Thank you for the opportunity to review and respond to the draft report. Please do not hesitate to contact our Executive Officer, Jane Adcock, at (916) 319-9343 or [jane.adcock@cmhpc.ca.gov](mailto:jane.adcock@cmhpc.ca.gov) should you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "John Ryan", is written over a horizontal line.

John Ryan, Chairperson

MS 2706  
PO Box 997413  
Sacramento, CA 95899-7413  
916.651.3839  
fax 916.319.8030

X INFORMATION

TAB SECTION: D

\_\_\_ ACTION REQUIRED: None

DATE OF MEETING: 10/16/13

PREPARED BY: Adcock

DATE MATERIAL

PREPARED: 09/18/13

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AGENDA ITEM: White Paper by Mental Illness Policy Organization

ENCLOSURES: • White Paper by Mental Illness Policy Organization

OTHER MATERIAL RELATED TO ITEM:

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ISSUE:



**California's Mental Health Service Act  
A Ten Year \$10 Billion Bait and Switch**

**An investigation by Mental Illness Policy Org and Individual Californians  
August 15, 2013**

Author  
DJ Jaffe  
Executive Director  
Mental Illness Policy Org

**MENTAL ILLNESS POLICY ORG.**  
UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA  
50 EAST 129 ST., PH7 NEW YORK, NY 10035  
[OFFICE@MENTALILLNESSPOLICY.ORG](mailto:OFFICE@MENTALILLNESSPOLICY.ORG)

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### **Note to Reporters and Good Government Groups:**

Most of the problems we found in MHSA accrued to the benefit of community based providers of voluntary “mental health” and social services. Hence, they tend to support what we identified as a major problem: the diversion of funds from people with serious mental illness to those with any mental health problem or social service need. The trade associations for these organizations (MHA, CCCMHA, CalMHSA, etc.) are not likely to find fault with the programs. This, combined with the over \$11 million the Oversight Commission has allocated to PR efforts explains why this problem has gone largely (not completely) unreported.

For that reason, we would suggest you contact experts in *serious* mental illness, versus mental health or social services when attempting to get other perspectives on this report. Experts who do deal with people with serious mental illness (ex: schizophrenia and bipolar disorder) include prison and jail officials; homeless shelter workers and doctors; psychiatric inpatient doctors and nurses; hospitalized, incarcerated or homeless patients; and perhaps most importantly, mothers of children with serious mental illness who have been shut out of care due to the diversion of funds. We have provided contacts for a few of these at the end.

### **About Mental Illness Policy Org:**

Mental Illness Policy Org is an independent, non-profit think tank dedicated exclusively to the study of serious mental illness, not mental health. We provide media, policymakers, and advocates with science based solutions to seemingly intractable problems like violence, incarceration, involuntary commitment and the need for more hospital beds. We have been credited as the driving force behind the adoption of Kendra’s Law in New York and multiple other advancements in the treatment and care of the most seriously ill. We became interested in California because passage of Prop 63--specifically intended to help the most seriously ill, made it the only state with enough money to make a major improvement in how the most seriously ill were treated. Over time, reports came to our office that the funds were being diverted to other purposes. As documented in this report, we investigated and found the reports to be true.

# California's Mental Health Service Act A Ten Year \$10 Billion Bait and Switch

## An investigation by Mental Illness Policy Org and Individual Californians August 2013

### Executive Summary

#### Background

In November, 2004 voters enacted a 1% tax on millionaires (Prop 63) to establish the Mental Health Services Act (MHSA) fund solely to help people with **serious mental illnesses**.<sup>1</sup> \$10 billion has been raised since inception. Voters also created a Mental Health Services Oversight and Accountability Commission (MHSOAC a/k/a "Oversight Commission") to see the program stuck to its purpose of helping people with serious mental illness.

#### Primary Findings

Many people with serious mental illness are receiving critical treatment as a result of Prop 63 but billions are being diverted to other purposes:

- \$1-2 Billion of Prevention and Early Intervention (PEI) Funds was intentionally diverted to social service programs masquerading as mental illness programs or falsely claim they prevent serious mental illness.
- \$2.5 billion of the "Full Service Partnership (FSP) funds were spent without oversight of whether the recipients had schizophrenia, bipolar disorder, or the other serious mental illnesses that made them eligible for MHSA funds.
- \$23 million went to organizations directly associated with Oversight Commissioners.
- \$11 million is going to PR firms that make the Oversight Commissioners look good and hide the failure of MHSA to accomplish its mission
- \$9 million is going to organizations working prevent the seriously ill from receiving treatment until after they become violent.
- Up to \$32 million was diverted to TV shows, radio shows, PSAs and other initiatives designed to reach the public without mental illness. Some feature the Senate President Pro Tem.

#### Additional Findings

- County Behavioral Health Directors chaired meetings that allowed "stakeholder input" to trump the legislative language and voter intent to spend the funds on those with serious mental illness.
- No attempt is made to ensure programs receiving MHSA funds serve people with serious mental illness.<sup>2</sup>
- MHSA funds are being lavished on studies, reports, and consultants that generate jobs for those who get the contracts, but not services for people with serious mental illness.<sup>3</sup>
- Millions were diverted to programs intended to 'improve the wellness' of all Californians, rather than provide treatment to Californians with serious mental illnesses.<sup>4</sup>
- Funds failed to expand the capacity of proven existing programs as the legislation required.
- The most important programs to help the most seriously ill (like Laura's Law) are going unfunded.
- The Oversight Commission evaluated counties based on what they said they were going to do rather than on what they did.
- A series of amendments and related legislation introduced by legislators made it less likely MHSA funds will ever reach people with serious mental illness.<sup>5</sup>

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<sup>1</sup> The purpose was to "To define serious mental illness among children, adults and seniors as a condition deserving priority attention. See the bill as originally passed <http://mentalillnesspolicy.org/states/california/prop63text.pdf> and as amended in 2012 [http://mentalillnesspolicy.org/states/california/mhsa/MHSA\\_Amend-AB1467\\_July2012.pdf](http://mentalillnesspolicy.org/states/california/mhsa/MHSA_Amend-AB1467_July2012.pdf)

<sup>2</sup> Many of the outcome reports are at <http://www.mhsoac.ca.gov/Evaluations/CSS-Outcomes.aspx>. They do not include any info on the diagnosis of people served.

<sup>3</sup> Ex. The Oversight Commission put out an RFP for an evaluation to evaluate the evaluations. Neither the original evaluations or the evaluation of the evaluations require evaluation of whether the people being served were seriously mentally ill individuals eligible for services. [http://mhsoac.ca.gov/Evaluations/docs/Contracts/RFP\\_MHSOAC012-015.pdf](http://mhsoac.ca.gov/Evaluations/docs/Contracts/RFP_MHSOAC012-015.pdf)

<sup>4</sup> The Oversight Commission itself created an eight page glossy insert for papers throughout the state headlined, "Mental Illness: It Affects Everyone, even though the legislation is not intended to affect everyone. See [http://issuu.com/news\\_review/docs/2013-01-03\\_mentalillness](http://issuu.com/news_review/docs/2013-01-03_mentalillness) (accessed 6/23/12).

<sup>5</sup> Most notably, AB-100 took \$863 million out of the MHSA fund and directed it to fund programs courts had mandated the state to fund. AB 1467 (July 2012) essentially disconnected Innovative Funds (5% of total MHSA funds) from a connection with serious mental illness.

This report will document each of these findings.

### **Who is responsible for the failure:**

#### The Oversight Commission

The problems with MHSA are not ‘under the radar,’ they are caused by the radar operators. The Oversight Commissioners have become cheerleaders for mission creep and cronyism rather than careful stewards of public funds. The Oversight Commissioners receive funds for their programs, approve distribution of the funds, hire outside evaluators to prove they are doing a good job and PR firms to convince the public all is well.

#### County Behavioral Health Directors

County behavioral directors--thirty-four of whom recently voted themselves MHSA-funded iPads<sup>6</sup>—have led and let the stakeholder process circumvent the language of the law and intent of the voters. They are funding anything brought to them by stakeholders, rather than limiting funding to serious mental illness programs.

#### California’s non-profit mental ‘health’ and social service industries

California’s non-profit mental health and social service industries provide an important safety net for many Californians. But in a gold-rush like attempt to garner funds for their own programs, they threw those with serious mental illness under the bus. Non-profits and associations like Disability Rights California, NAMI California, Mental Health America of California, each of which receive over \$3 million and have representation on the Oversight Commission put their own parochial needs ahead of those of people with serious mental illness.

#### Senate President Pro-Tem Darrell Steinberg and the Legislature

Many of the citizens who contributed information to this report told us the Senate leader’s heart is in the right place and he can be part of the solution. Unfortunately, when we look at the facts, we are forced to conclude that since passage, the Senate President Pro-Tem Steinberg has been part of the problem. He introduced and the legislature passed numerous bills that subverted the intent of voters to use the funds to help the most seriously ill. SB 1467 ensured fewer Innovation Funds reached persons with mental illness.<sup>7</sup> Provisions he inserted in AB-100 diverted \$836 million of MHSA funds to fund pre-existing state obligations<sup>8</sup>. His opposition to SB 664 made it harder for counties to implement Laura’s Law. His opposition to AB-1265 guaranteed mentally ill prisoners would go untreated upon end of their sentence. SB-364 as proposed made it more dangerous for parents to call authorities to help mentally ill loved ones. We would love to see the Senator resume a leadership role in improving services for people with serious mental illnesses. Recommendations on how to do so are attached.

**Conclusion:** It is undeniable that some people with serious mental illness are being helped by MHSA, but **unmitigated mission creep has left many of the most seriously mentally ill seriously underserved.** There is an unregulated feeding frenzy going on and Prop 63 is on its way to becoming a **“Ten Year, \$10 Billion Bait and Switch.”**

**Someone should go to jail.**

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<sup>6</sup> Through CalMHSA, a Joint Power Authority funded with MHSA Prevention funds.

<sup>7</sup> See Appendix C. How Senate President Pro-Tem Exempted an additional 5% of MHSA funds (Innovative Services Funds) from helping persons with serious mental illness.

<sup>8</sup> There is a “non-supplantation” clause of Prop 63 (5891) that required the maintenance of funding for previously existing programs so MHSA funds can result in incremental activity. AB-100 used MHSA funds to pay for programs California was already under court order to pay or was otherwise funding. Put another way, \$836 million of MHSA funds were used to lower the budget deficit.

# Recommendations

## 1. Focus Programs on those voters intended: people with the most serious mental illnesses

- Require counties to report and monitor MHSA expenditures *by diagnosis*.
- Eliminate all regulations and guidance that diverted MHSA funds to people without mental illness and inform counties they are no longer operative.
- Eliminate funding of programs that falsely claim they prevent serious mental illness
- Eliminate funding of programs that refuse to accept people with serious mental illness
- Define "Underserved Populations" by diagnosis and severity of their mental illness.
- Eliminate spending on PR, TV shows, PSAs ("Universal Prevention Activities") and spend the money saved on helping people with serious mental illness
- Expand programs that existed prior to Prop 63 that successfully treated people with serious mental illness.
- Require Prevention and Early Intervention (PEI) funds to be spent, as legislatively required, on 'preventing mental illness from becoming severe and disabling', not 'preventing mental illness' (since no one knows how to prevent serious mental illnesses like schizophrenia and bipolar disorder.)
- Eliminate funding of organizations that do not believe mental illness exists or lobby--even with non-MHSA funds--against treatment for those who are so sick they do not recognize their need for treatment.
- Eliminate the ability of County Behavioral Health Directors to lead or follow a stakeholder process that perverts and circumvents intent of legislation. (i.e., use science based rules rather than mob rules to distribute funds)

## 2. Overhaul the Oversight Commission

- Individuals responsible for distributing or receiving MHSA funds should not be allowed on oversight committees because they have a conflict of interest.
- Prohibit Insider Dealing: No funds should go to programs associated now, or within the last five years with board members of the Oversight Commission.
- Increase percentage of criminal justice representatives on Oversight Commission because they know what community services are needed to prevent arrest and incarceration of the most seriously ill
- Increase representation from inpatient psychiatric hospitals on oversight commission as they know what community services are needed to prevent rehospitalization of the most seriously ill

## 3. Use legislative and legal process to further voter intent, rather than divert funds to non related programs

- Pass legislation to clarify that individuals under Laura's Law are eligible for MHSA supported services.
- Amend MHSA to allow funding for people with serious mental illness paroled from state prisons
- Overturn AB 1467 which severed Innovative Funds from helping people with serious mental illness
- Refer illegal expenditures to Attorney General

## Unmitigated Mission Creep: MHSA fails to stick to the mission of serving individuals with serious mental illness

When campaigning for Proposition 63, Senator Steinberg and mental health trade association head, Rusty Selix promised voters the funds would help people with **serious** mental illness.

*“This measure will provide mental health services to **people who need it most.**” (emphasis added) –Darrell Steinberg March 23, 2004<sup>1</sup>*

*“And (voters) didn’t want (Proposition 63) to fund all mental health, only people that had severe mental illness.”  
Rusty Selix<sup>2</sup>*

Proposition 63 Findings and Declarations differentiated between mental illnesses and serious mental illnesses

*“Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. **In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%.** Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year.*

Proposition 63 made clear it was to help get services to people with serious mental illnesses:

*Purpose and intent: To “define **serious mental illness** among children, adults and seniors as a condition deserving **priority** attention...to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from **untreated serious mental illness**...To expand...programs have already demonstrated their effectiveness in providing ...**medically necessary psychiatric services**, and other services, to individuals **most severely affected** by or at risk of **serious mental illness.**”*

There is little controversy as to who has “serious” mental illness. Proposition 63 and virtually all government agencies and non profits use roughly 5-9% of the population because they all rely on the National Institute of Mental Health (NIMH)<sup>3</sup> the pre-eminent research arm of the US Government that addresses these issues. 5-9% is also supported by other research.<sup>4</sup> NIMH estimates overall 5% have “Serious Mental Illness” and breaks it down by diagnosis as follows:

Schizophrenia (NIMH defines <i>all</i> schizophrenia as “severe”)	1.1% of the population <sup>5</sup>
The subset of major depression called “severe, major depression”	2.0% of the population <sup>6</sup>
The subset of bipolar disorder classified as “severe”	2.2% of the population <sup>7</sup>
<b>Total “severe” mental illness by diagnosis:</b>	<b>5.3% of the population<sup>8</sup></b>

The above are overall figures. Within certain age groups NIMH research shows up to 8% have serious mental illness. This accounts for the 5-9% figure used in the legislation.<sup>9</sup>

In spite of the above, MHSA funds are being used on people who may have any type of mental health problem rather than those with serious mental illness as required by the legislation. Worthy and unworthy social service programs started masquerading as mental health programs to make them eligible for funding. Tutoring, unemployment, bullying initiatives, crime reduction, bad marriages, prostitution, were all defined as mental health issues eligible for funding.

<sup>1</sup> “Campaign for Mental Health” a blog by Darrell Steinberg to pass Proposition 63. The quote is from the very first post after turning in the signatures needed to put the initiative on the ballot. Available at [http://campaignformentalhealth.typepad.com/darrell/2004/03/campaign\\_turns\\_1.html](http://campaignformentalhealth.typepad.com/darrell/2004/03/campaign_turns_1.html) Accessed 7/19/13.

<sup>2</sup> “History of Mental Health in California” 4/5/10. UCLA Health Services Research Center Rusty Selix interview available at <http://www.mhac.org/pdf/Rusty-Selix-Interview.pdf>

<sup>3</sup> <http://www.nimh.nih.gov>

<sup>4</sup> 1. United States Public Health Service Office of the Surgeon General (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service. 2. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (2002). *National Household Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems*. 3. Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J. et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, 36, 987-1007.

<sup>5</sup> NIMH, Schizophrenia. “Schizophrenia is a chronic, severe, and disabling mental disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness. <http://www.nimh.nih.gov/statistics/1SCHIZ.shtml>

<sup>6</sup> “2.0% of U.S. Population is are classified as “severe”, NIMH “Major Depressive Disorder Among Adults” [http://www.nimh.nih.gov/statistics/1MDD\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml)

<sup>7</sup> NIMH “Bipolar Disorder Among Adults” “2.2% of U.S. adult population are classified as “severe””. [http://www.nimh.nih.gov/statistics/1BIPOLAR\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/1BIPOLAR_ADULT.shtml)

<sup>8</sup> “Prevalence of Serious Mental Illness Among U.S. Adults by Age, Sex, and Race in 2008 (NSDUH)” at [http://www.nimh.nih.gov/statistics/SMI\\_AASR.shtml](http://www.nimh.nih.gov/statistics/SMI_AASR.shtml)

<sup>9</sup> California’s definitions can be found at 5600.3

## Prevention and Early Intervention: How up to \$2 billion was diverted to programs that did not serve people with serious mental illness or falsely claimed they prevent mental illness.

**Case Study:** Monterey attempted to use MHSAs PEI funds as intended: to prevent those *with* mental illness from having it become 'severe and disabling'. The Oversight Commission stopped them:

"To be consistent with this (Prevention) definition, MHSAs-funded PEI programs *cannot serve people with a mental health diagnosis*. Several of Monterey County's PEI programs currently target mental health consumers; however, to be consistent with the PEI Guidelines, please clarify that these programs include persons **without a mental health diagnosis**." Letter available at [http://mhsaac.ca.gov/Countries/PEI/docs/PEIplans/PEI\\_Monterey.pdf](http://mhsaac.ca.gov/Countries/PEI/docs/PEIplans/PEI_Monterey.pdf) (Accessed 6/22/13)

### Background:

20% of MHSAs Funds-- \$2 billion to date--were earmarked for Prevention and Early Intervention (PEI) Programs.<sup>10</sup> PEI programs are required to operate within the overall intent of Prop 63 which is to give "*serious mental illness...priority attention*." PEI programs were created to "prevent mental illness from becoming **severe and disabling**", "to reduce the duration of **untreated mental illness**, or reduce certain negative outcomes that "result from **untreated mental illness**". Limited other usage is allowed but they must be connected to 'serious' or 'severe' mental illness.

The Prevention and Early Intervention program was not created to "prevent mental illness" because we do not know how. As Senator Darrel Steinberg eloquently stated when campaigning for Prop 63:

*"As I've said before, we can't prevent certain mental illnesses, such as schizophrenia and bipolar disorder, but we can prevent them from becoming severe and disabling."* –Darrel Steinberg. 4/13/2004<sup>11</sup>

PEI is designed to help those already with "mental illness" (20% of population)<sup>12</sup> from developing a "serious mental illness" (5-9%).<sup>13</sup> We do know how to do that. For example, if someone has schizophrenia or bipolar disorder, maintaining them in treatment, often medications, can prevent the disorder from becoming 'severe and disabling'. See *Appendix A* for a more detailed explanation of allowable uses of PEI funds.

### Problems

- At least \$1 billion (50% of the PEI funds) was diverted to people without mental illness.
- Approximately \$1 billion is being diverted to programs that falsely claim they 'prevent mental illness'.
- People with the most serious mental illnesses are being excluded from PEI programs.

**Oversight Commission guidance encouraged counties to exclude people with mental illness from PEI funded programs. Counties readily agreed.** The Oversight Commission's PEI Guidelines provided to counties state "Prevention Programs are expected to focus on individuals 'prior to' diagnosis"<sup>14</sup> In other words: people without mental illness. This was done in spite of the fact the legislation requires the funds to serve people with mental illness not those without. This direction accounts for the bulk of the \$2 billion that was diverted.

**The Oversight Commission and counties disguised worthy and unworthy social service programs as mental illness prevention programs in order to make them eligible for MHSAs funding.** The Oversight Commission issued and enforced a regulation that defined seven priority population groups as eligible for PEI funds.<sup>15</sup> Only one group was "Individuals experiencing onset of a serious mental illness". The other priority population groups are not required to be individuals experiencing onset of mental illness. They were being prioritized for services based sexual orientation, employment status of parents, presence of parents, whether or not someone in the family ever died, age, criminal history and substance abuse—even in the absence of a mental illness. None of these so-called 'risk factors' cause

<sup>10</sup> WIC 5840

<sup>11</sup> Official Weblog of the Campaign for Mental Health, April 13, 2004. Created by Darrel Steinberg to get voters to pass MHSAs. Available at [http://digital.library.ucla.edu/websites/2004\\_996\\_010/darrell/2004/04/index.html](http://digital.library.ucla.edu/websites/2004_996_010/darrell/2004/04/index.html) Accessed 6/20/13

<sup>12</sup> Substance Abuse and Mental Health Services Agency (SAMHSA) available at <http://www.samhsa.gov/newsroom/advisories/1211273220.aspx> (Accessed June 14, 2013)

<sup>13</sup> NIMH and Mental Health Services Act Findings

<sup>14</sup> Minutes of September 22, 2011 MHSOAC Commissioners. Available at [http://www.mhsaac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://www.mhsaac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf) Accessed 6/24/13.

<sup>15</sup> CCR Title 9 3905 lists 7 priority populations. However, nothing in the reg requires those priority populations to have a mental illness for which treatment is needed to prevent it from becoming severe and disabling.

schizophrenia, or bipolar or other serious mental illnesses. They are at best, social service concerns.

**The Oversight Commission forced counties to prioritize those least likely to have a serious mental illness.** The Oversight Commission required 51% of PEI funds go to children and youth between age 0 and 25.<sup>16</sup> Serious mental illnesses like schizophrenia rarely manifest themselves before late teens and early twenties. There is no way to predict who will get it until they symptoms manifest. To the extent the funds are being used in prior to late teens, they are not reaching those most likely to develop serious mental illness.<sup>17</sup>

**The Oversight Commission freed PEI programs from the requirement to measure outcomes.**<sup>18</sup>

**The Oversight Commission freed counties from using the funds as they said they would use them.**<sup>19</sup>

**The Oversight Commission freed counties from having to use evidence based practices.**<sup>20</sup>

#### Diverting Funds via Regulations:

**Officials issued regulations redefining the purpose PEI Funds so they could be spent on people without mental illness.**<sup>21</sup> Some examples:

- 3200.251 redefined the purpose of PEI programs from what voters intended ( “preventing mental illness from becoming severe and disabling”) to “prevent serious mental illness” (we don’t know how); “promoting mental health” (making people happier) and “building the resilience of individuals”.
- 3400 (b) illegally separated PEI programs from having the statutory tie to serious mental illness. The first part of the regulation states “Programs and/or services provided with MHSA funds shall: (1) Offer mental health services and/or supports to individuals/clients **with** serious mental illness and/or serious emotional disturbance, and when appropriate their families. But it goes on to state “**The Prevention and Early Intervention component is exempt from this requirement.**” There is nothing in voter intent or legislative language that suggest PEI funds were ‘exempt’ from helping people *with* serious mental illness. This exempted \$2 billion in taxpayer Prevention and Early Intervention funds from serving people with mental illness.
- 3200.305 encouraged counties to spend on so-called “Universal

#### **The science of prevention and early intervention:**

Any program that purports to prevent bipolar disorder or schizophrenia by intervening before it is diagnosed is making a false claim. Bad parents, bad grades, bad marriages, bad jobs, bad housing, bullying, and in most cases, loss of loved ones do not cause serious mental illness although they may exacerbate symptoms in those who already have it.

Serious mental illnesses are likely caused by a combination of genes, gene stressors, neuroanatomical differences and chemical imbalances. There is no test to predict who will develop serious mental illness before symptoms materialize making many so-called early intervention programs ineffective.

Schizophrenia usually manifests itself in late teens and early twenties. The illness occurs in 1% of the general population, 10% who have a parent or sibling with the disorder; and 40-65% of those who have an identical twin with the disorder. Problems in utero may trigger the disorder in those genetically predisposed. Diagnosis is made by eliminating other causes and analyzing the effect of the disorder on the individual.

Bipolar disorder often develops in a person's late teens or early adult years. Children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness, compared with children who do not have a family history of bipolar disorder.

Improving employment, grades, marriage satisfaction, etc. does not reduce the incidence of serious mental illness and is not a targeted intervention. Targeted interventions would aim at the offspring of those with mental illness, not those without.

<sup>16</sup> [http://www.mhsoac.ca.gov/MHsoAC\\_Publications/docs/FactSheet\\_PEI\\_121912.pdf](http://www.mhsoac.ca.gov/MHsoAC_Publications/docs/FactSheet_PEI_121912.pdf) Accessed 6/24/13.

<sup>17</sup> Oversight Commissioners quote a figure that half of mental illness begins before age fourteen. But that is not ‘serious mental illness’. MHSA was passed to “define serious mental illness” not all mental health, as a condition deserving priority attention. Serious mental illness usually first becomes manifest in late teens early twenties. Other issues like bad grades, lack of self-esteem, anti-social behavior do present themselves earlier but are outside the scope of MHSA.

<sup>18</sup> The commissioners were told by their own evaluator that there is “no requirement (for counties) to measure outcomes” This allowed a massive diversion to programs that were politically popular regardless of their utility. Minutes of September 22, 2011 MHsoAC Commissioners. Available at [http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf)

<sup>19</sup> During the period of this review, the legislation required counties to submit PEI plans to the Oversight Commission for review. Minutes show that MHsoAC review of counties was “based on what counties said they were going to do, rather than actual on the ground assessment”. [http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf)

<sup>20</sup> Voters included a specific *legislative finding* that “By expanding programs that have demonstrated their effectiveness, California can save lives and money.” At a MHsoAC board meeting, MHsoAC Vice-chair Van Horn admitted “there are not a lot of evidence-based practices (being used) in the PEI arena.” He then went on to lower the standards a program has to meet: “PEI Guidelines have requirements that counties must use *some* level of evidence to support the programs that they are proposing. It doesn’t have to be evidence-based practice; it could be a range of evidence.”

<sup>21</sup> Some of these were promulgated, some not, some lapsed. As will be seen in next section, the direction to not use PEI funds for persons with mental illness was continually and forcefully communicated to counties and was defacto policy regardless of which regulations were in effect.

Prevention Activities.” That “*target the whole population or a subset of the population that does not have a higher risk for developing the symptoms of mental illness.*”<sup>22</sup> It takes the most tortured reading of Prop 63 to conclude that voters intended to fund PR campaigns, television shows, newspaper advertising, etc. for people without mental illness.

(See Appendix C for more Regulations that were proposed at various times).

#### **Commissioners kept ineffective programs funded.**

1. At an MHSOAC board meeting, “Commissioner Vega pointed out that results from some PEI programs, particularly those involving youth, cannot be known until years later.” This claim is frequently used to justify continuing unproven programs. The reason programs for youth don’t work to “prevent mental illness from becoming severe and disabling” is (1) they are not targeting those most likely to develop serious mental illness (first degree relatives of people with serious mental illness; (2) they are not targeting people with mental illness; and (3) there is not yet a known way to prevent serious mental illness.
2. At an MHSOAC board meeting a Los Angeles FSP Program Manager admitted the L.A. job training program had only increased employment days 4.2 percent and that was mainly due to government creating jobs versus any private sector jobs being created.<sup>23</sup> The program continues to receive funding.

**Commissioners intended to (may have) approved expenditures they knew were not allowable by law.** Oversight Commission minutes show that the commissioners funded substance abuse programs specifically not included for funding in the final language of the legislation. “MHSOAC Vice-Chair Van Horn commented that ...the reason co-occurring disorders (substance abuse) were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition.” He then went on to state, “**It is clear that co-occurring disorders need to be dealt with at the same level.**”<sup>24</sup> In spite of not including this in the legislation, Commissioner Van Horn clearly expressed his intent to fund it.<sup>25</sup>

**Oversight Commissioner and counties fail to address waste and diversion of funds.** The Associated Press, San Francisco Chronicle<sup>26</sup>, as well as our own op-eds<sup>27</sup> and letters to the Oversight Commission have attempted to bring the problems in PEI programs to their attention so they could be remedied. The Oversight Commission has ignored the reports, defended the status quo, and in at least one instance threatened a newspaper that was thinking of reporting on the problems with having their advertising pulled.<sup>28</sup>

#### **County behavioral healthcare directors encourage, lead, and fail to overrule a flawed stakeholder process that diverts funds**

Proposition 63 established stakeholder process to advise counties on spending. While county behavioral health commissioner are supposed to consider this input, they allowed participants to prioritize non-evidenced programs; programs that don’t serve people with serious mental illness; and caused programs that help the most seriously ill to go without funding. In many if not most counties, the Behavioral Health Directors actually lead the meetings. (See chapter on “Failed Stakeholder Process”).

See following section for examples.

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<sup>22</sup> <http://www.preventionearlyintervention.org/go/PromotingWellnessPrevention/UniversalPrevention.aspx>

<sup>23</sup> “Commissioner Poat, Mr. Delgado, and Mr. Refowitz agreed that employment is a challenging need to meet in the whole recovery process. The hiring freeze in Orange County and the overall downturn in the economy have made it harder to find employment for FSP graduates.”

<sup>24</sup> Minutes of MHSOAC Board Meeting September 22, 2011. Available at [http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf) Accessed 6/24/12

<sup>25</sup> From a policy perspective, we agree with Commissioner Van Horn that funding co-occurring substance abuse in people who have serious mental illness or mental illness that needs treatment to prevent it from becoming severe and disabling, makes sense. But the point for this report, is that it is not allowable, he knew it, yet was still trying to achieve it.

<sup>26</sup> <http://www.sfgate.com/opinion/article/Prop-63-Mental-Health-Services-Act-not-as-3688777.php>

<sup>27</sup> <http://mentallillnesspolicy.org/states/california/capitalweeklyoped.html>

<sup>28</sup> This is the only fact we are making in this report that we will not provide additional documentation for. That is because we want to protect the identity of the reporter. After s/he questioned an MHSA official, MHSA PR operation reached out to the publisher and threatened to pull advertising. The reporter was, according to him/her chastised, and the story killed.

## Examples of statewide misspending within PEI (and/or Innovation Funds)

**Case Study:** According to a reporter at the Orange County Register reported suicide in California is up and the MHSAs suicide prevention program is not working:

*“Jenny Qian, a manager in county behavioral services, says thanks to an injection of money from Proposition 63, Orange County has beefed up its suicide programs in the past two years and continues to roll out more programs. Qian tells me by calling what she describes as a local hotline number, 1-877-727-4747, people will find all the local help they need.”*

*“I called that number and asked for help for someone needing a counselor in the Mission Viejo area. I was informed the person who needs help should call. I pressed and was told they can't help with local counselors because the service is nationwide.”* <http://www.ocregister.com/articles/suicide-504805-county-gun.html>

### Statewide Prevention and Early Intervention Initiatives (\$129 million)<sup>29</sup>

MHSA PEI funds are generally given to counties to spend. However, there are two sources of statewide funds.

1. CalMHSA. CalMHSA is a Joint Power Authority created by counties to pool their MHSA funds to execute programs that are more efficiently executed by a statewide entity, rather than by individual counties. These expenditures must still comply with MHSA requirement to serve people with serious mental illness, “prevent mental illness from becoming severe and disabling” or “reduce the duration of untreated serious mental illness. They were still subject to approval by the Oversight Commission. CalMHSA bought 34 Ipads for County Behavioral Health Directors.<sup>30</sup>
2. Oversight Commission- The Oversight Commission has extensive funds of their own. These are generally used for reports, studies, and research, that create good press for the commission, jobs for those who get the contracts, but have very little to do with providing care to people with serious mental illness. While these come out of administrative funds (rather than PEI) we will discuss them here.

It is often difficult to determine which MHSA funded projects described below were funded from which buckets of money, but the fact that MHSA funds are being used is indisputable.

### 1. Suicide Prevention wastes up to \$32 million<sup>31</sup>

**Background:** Suicide is mentioned twice in MHSA. The “Findings and Declarations” declared, “Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government.” and “The (PEI) program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide.”<sup>32</sup> MHSA is only to reduce suicide that results from untreated mental illness. California previously created a “Strategic Plan on Suicide Prevention” (a/k/a “Schwarzenegger Plan<sup>33</sup>) that included data and strategies to prevent suicide and noted mental illness was a leading cause of suicide.<sup>34</sup>

**Problems:** CalMHSA ignored the research included in the Schwarzenegger Plan and funded non evidenced based suicide programs instead. For example, the Schwarzenegger Plan found kids 10-15 are the lowest suicide risk but CalMHSA focused PEI suicide money on children. Adults, the group with the highest death rates—responsible for 50% of all suicides are not prioritized.

**Prop 63 funding is funding ineffective, unproven, mistargeted TV, radio, billboard, print campaign to**

<sup>29</sup> A description of some of the statewide programs with dollar amounts is at [http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC\\_072811\\_Tab3\\_CalMHSA\\_StatusReport.pdf](http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf). Some are annual expenditures. Others may be multi-year.

<sup>30</sup> See last page, last paragraph at <http://calmhsa.org/wp-content/uploads/2012/06/CalMHSA-Budget-Package-2012-2013-FINAL.pdf>

<sup>31</sup> \$129 million was spent on CalMHSA on PEI of which 25% was allocated to suicide (\$32 million). Page three at <http://calmhsa.org/wp-content/uploads/2012/01/CalMHSA-Implementation-Work-Plan-FINAL-11-18-10-POSTED.pdf> \$3 million of this suicide prevention funding went to NAMI, whose former President Ralph Nelson was on MHSAC Board. \$3 million of this went to MHA of SF, whose former Executive Director, Eduardo Vega was on MHSAC board.

<sup>32</sup> WIC 5840(d)(1)

<sup>33</sup> <http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf>

<sup>34</sup> “(N)early half of suicide cases involve at least one documented mental health diagnosis. It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder. Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder (a spectrum that includes major depression and bipolar disorder), up to 20 percent die by suicide. The risk tends to be highest among those who have frequent and severe recurrences of symptoms.”

**reduce suicide.**<sup>35</sup> There is no evidence that media campaigns reduce suicide and some evidence they increase it<sup>36</sup>. It is also inefficient because they reach the general public versus high risk populations like those with serious mental illness, those who have previously attempted suicide, or the first degree relatives of those who have attempted suicide.<sup>37</sup>

CalMHSA also uses MHA funds for anti-suicide websites like <http://www.yourvoicecounts.org> Your Voice Counts lets Californian's vote on what is effective at suicide prevention. It substitutes polling for science in deciding where MHA Suicide prevention money should go.

## 2. Stigma and Discrimination Reduction wastes up to \$48 million<sup>38</sup>

MHA eloquently differentiated 'extremely common' mental illnesses from serious mental illnesses and stated the intent of the legislation to help the later and not the former.<sup>39</sup> In spite of this, stigma funds are being spent on those with common illnesses and not those with serious mental illnesses.

- A glossy four-color magazine insert was produced, printed, and distributed statewide in newspapers that is headlined, "Mental Illness Affects Everyone." That was clearly not designed to inform about the much smaller group with 'serious' mental illness<sup>40</sup>.
- A TV commercial in five languages was produced<sup>41</sup>:
  - Title "One in Four"*
  - Anncr: Every year, 1 in 4 Californians experience mental illness.*
  - Mental illness does not discriminate.*
  - It can happen to anyone of any ethnicity, income or gender.*
  - It is a medical condition that affects thinking, feeling, mood, ability to relate to others, daily functioning.*
  - There are many causes including life history particularly stress, trauma, abuse.*
  - If you or someone you know is hurting, get help. Contact your county mental health or behavioral health*

<sup>35</sup> The CalMHSA suicide prevention efforts have a \$32 million budget, but we don't know what percentage is being spent on this particular effort. <http://www.prweb.com/releases/prweb2012/12/prweb10229719.htm>

<sup>36</sup> The theory behind these campaigns is that they educate people to see warning signs so they can intervene to prevent the suicide. But research shows it doesn't work mainly because suicide is exceedingly uncommon. Per the press release announcing the CalMHSA Suicide Prevention Media Campaign, of the 37.5 million Californians, 3,823 (.01%) took their own lives, and 16,425 (.04%) were hospitalized for self-inflicted injuries. To be effective, all experts agree that suicide prevention efforts should be highly targeted to those populations with higher rates of suicide or attempts. Populations with high rates of suicide include those who have previously attempted suicide and first degree relatives of those who have attempted suicide. It is simply a waste to fund TV campaigns when trying to reach less than 4,000 or 17,000 people.

We researched the professional literature and could not find any scientific evidence media campaigns reduce suicide. There are reputable sources that suggest (without proof) that these campaigns should be used, but in almost all cases they say the campaigns should be targeted at high-risk individuals.

The Suicide Prevention Resource Center does not list any public relations campaigns in their list of "Evidence Based Programs" They do list education and training, but these are targeted to 'gatekeepers', like nurses, doctors, and social workers so they can recognize symptoms. See <http://www.sprc.org/bpr/section-i-evidence-based-programs#sec1listings>

The Schwarzenegger Plan does suggest public education efforts (without citing any source or rationale) but immediately goes on to suggest that targeting gatekeepers is the most important strategy <http://mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf>

There are many studies showing efforts targeted to the public are not supported by research. See *Suicide Prevention Strategies: A systematic review Journal of the American Medical Association* available at <http://jama.jamanetwork.com/article.aspx?articleid=201761> and *Why are we not getting any closer to preventing suicide? DIEGO DE LEO, FRANZCP BJ Psych* available at <http://bjp.rcpsych.org/content/181/5/372.short> *The later sates* "The conflict between political convenience and scientific adequacy in suicide prevention is usually resolved in favor of the former. Thus, strategies targeting the general population instead of high-risk groups (psychiatric patients recently discharged from hospital, suicide attempters, etc.) may be chosen"

We also contacted Dr. Alan Berman Executive Director of the American Association of Suicidology, to triple check our findings. He confirmed that there is no evidence PR campaigns reduce suicide and confirmed the research that they may in fact do harm (have 'untoward' effect).

<sup>37</sup> Spending \$32 million to reach 3,832 (est.) individuals results in a per capita expenditure of \$8,370 per suicide prevented.

<sup>38</sup> 37.5% of \$129 million per California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan page iii at <http://calmhsa.org/wp-content/uploads/2012/01/CalMHSA-Implementation-Work-Plan-FINAL-11-18-10-POSTED.pdf>

<sup>39</sup> After noting that mental illnesses are "extremely common" MHA findings and declarations went on to state that these people with everyday common mental illnesses are not serious mental ill that MHA was intended to help, "In any year, between 5 percent and 7 percent of adults have a serious mental illness as do a similar percentage of children— between 5 percent and 9 percent. " MHA funds are intended to 'define *serious mental illness* as a condition deserving priority attention".

<sup>40</sup> Available at [http://issuu.com/news\\_review/docs/2013-01-03\\_mentalillness](http://issuu.com/news_review/docs/2013-01-03_mentalillness)

<sup>41</sup> Available on right side at [http://www.mhsoac.ca.gov/Prop63\\_Website/Prop63\\_NewWebsite.aspx](http://www.mhsoac.ca.gov/Prop63_Website/Prop63_NewWebsite.aspx)

This PSA does not even mention "serious" mental illness. The PSA misstates the science<sup>42</sup> and proposes a solution that will not likely work for many of the most of the seriously ill.<sup>43</sup>

- Five "Mental Health Minutes" (sponsorships) were produced.<sup>44</sup> Only one mentions serious mental illness.
- **\$11 million in stigma funding was given to a Sacramento public relations firm (Runyon Saltzman & Einhorn).**<sup>45</sup> Among other tasks, they ran a Facebook group "Good News About Proposition 63". It did not provide any information to help people with mental illness, only puff pieces on how great Prop 63 is. When people started posting info about waste and fraud within Prop 63, rather than look at the site as useful tool to collect such information, they took the page down. The PR firm also writes op-eds extolling the virtues of MHSA<sup>46</sup> and generates positive news stories.<sup>47</sup> These efforts have made it very difficult for the truth about Prop 63 to get out to the public. Voters did not pass prop 63 because they felt a dearth of PR firms.
- **\$2.9 million in stigma funding is going to Disabilities Rights California (DRC)<sup>48</sup> and is being used to oppose Laura's Law<sup>49</sup>** a program that has been proven to help people who are so seriously ill they do not recognize their need for treatment<sup>50</sup>.
- **Approximately \$12 million in stigma funds were given directly to organizations headed by members of the Oversight Commission.** See Insider Dealing chapter for information on approximately \$3 million each in stigma funds given to NAMI, MHSA, and DRC all of which are headed by members of the Oversight Commission.
- **Stigma funds were used to tell newspaper reporters and editors how to write their stories.**<sup>51</sup>
- **Stigma funds were used to produce a documentary film for TV.**<sup>52</sup> When the Sacramento Bee questioned the use of MHSA funds to produce public television shows, the MHSA PR firm stated "it was tremendously successful," pointing to an increase in traffic at a website, ReachOut.com, and viewers of the PBS show". But creating visitors to a website or viewers for a television show was not the purpose of MHSA. Some PSAs in Sacramento now feature the Senate Leader Pro Tem.

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<sup>42</sup> "Serious" mental illness is not caused by "stress, trauma, abuse" like the PSA says. Serious mental illness like schizophrenia is likely due to multiple interrelated genes somehow interacting with external influences like viruses. It may be a disorder incurred in-utero. Bipolar disorder, the other serious mental illness Prop 63 proceeds were intended to help is even more genetically related than schizophrenia. The "one in four" mental illnesses may not "affect...daily functioning" as the PSA says. It is the "serious" mental illnesses (that affect 5-9% of people) that are likely to "affect...daily functioning". Put another way, the author of this report has depression and takes Prozac. It doesn't affect his daily life at all. He's a "1 in 4" not a 5-9%. MHSA was not intended to serve me. The language of the legislation, and materials used to sell it to the public, clearly state Prop 63 is intended to serve the **seriously** ill.

<sup>43</sup> Up to 50% of those who have *schizophrenia or bipolar* and are not currently receiving treatment may be so ill they don't recognize they have it. It's called anosognosia. Lack of awareness of illness (a brain so sick it doesn't know it is not working) is the Number One reason people with serious mental illness won't accept treatment. So admonishments to "Get Help" will not work.

<sup>44</sup> Available on left side at [http://www.mhsoac.ca.gov/Prop63\\_Website/Prop63\\_NewWebsite.aspx](http://www.mhsoac.ca.gov/Prop63_Website/Prop63_NewWebsite.aspx)

<sup>45</sup> <http://www.californiahealthline.org/articles/2011/10/18/agency-doles-out-11-2m-for-mental-health-campaign.aspx>

<sup>46</sup> <http://www.mhsoac.ca.gov/ArchivedOpinionEditorials.aspx>

<sup>47</sup> <http://www.mhsoac.ca.gov/ArchivedInTheNews.aspx>

<sup>48</sup> Oversight Commissioner Eduardo Vega is on the DRC board.

[http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC\\_072811\\_Tab3\\_CalMHSA\\_StatusReport.pdf](http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf)

<sup>49</sup> <http://lauras-law.org/states/california/llresultsin2counties.html>

<sup>50</sup> According to Carla Jacobs of California Treatment Advocacy Coalition, DRC sued Los Angeles to prevent implementation of Laura's Law. For some 2005-2012 DRC anti-Laura's Law activity see <http://lauras-law.org/states/california/p&aopposition.pdf>

<sup>51</sup> At least one editor of one large California Daily was approached by MHSA funded stigma program which wanted her to use their "style guide" to change how she was writing about mental illness, i.e., downplay violence.

<sup>52</sup> The documentary was called, "A new state of mind: Ending the Stigma of Mental Illness. The Sacramento Bee ran a story on it "Public Eye: State Funding of Mental Health Documentary Questioned" See <http://www.sacbee.com/2013/06/02/5464315/state-funding-of-mental-health.html>. In response to the criticism, the PR firm responded that the documentary was successful because

## Examples of county social service programs masquerading as mental illness programs<sup>53</sup>

Many of the county programs below that came to our attention are admirable, worthy and even important social service programs. But they are not mental illness programs. They are therefore ineligible for MHSA funding. Diverting MHSA funds to these programs is not what voters intended, and leaves those with serious mental illness living untreated at home or homeless, living under lice infected clothing and eating out of dumpsters, while funds intended to help go elsewhere.

- **Butte County** uses MHSA funds for
  - A "Therapeutic Wilderness Experience".<sup>54</sup>
  - Hmong Gardens.<sup>55</sup> This is a good example of a failed stakeholder process. Butte did a study of the need for housing for people of Hmong ancestry.<sup>56</sup> Eight people participated. We do not know if any had serious mental illness or if any housing was ever built. But this focus group found that two important services for this housing that is not limited to people with mental illness are "gardens" and a "community room". The researchers aggregated the two to conclude that if they built housing, 58% wanted "community room and garden" and therefore a garden was a service that prevents mental illness from becoming severe and disabling.
  - African American Cultural Center.<sup>57</sup>
  - PR brochures that positioned the county behavioral health director as an effective steward of MHSA funds. They include no financial data on how the money is spent.<sup>58</sup>
- **Contra Costa County** is using MHSA funding
  - To teach parenting skills to parents(\$360,000)<sup>59</sup>
  - for a hip-hop carwash, family activity nights and a homework club.<sup>60</sup>
  - to help the elderly with or without mental illness.<sup>61</sup>
  - "New Leaf Collaborative."<sup>62</sup> This works to improve grades.
  - Native American Health Center<sup>63</sup>.
  - Lesbian, Gay and Transgender programs. Being lesbian gay or transgender are no longer considered mental illness. There is no evidence that being lesbian gay or transgender makes someone more likely to develop a serious mental illness like schizophrenia and bipolar.<sup>64</sup>

<sup>53</sup> These are only the ones we have become aware of, and do not represent a complete list. We did not evaluate every county MHSA plan, only programs that came to our attention.

<sup>54</sup> We are not aware of any information that shows a Therapeutic Wilderness Experience will prevent mental illness from becoming severe and disabling [http://www.mhsoac.ca.gov/Innovation/docs/InnovationPlans/Butte\\_INN\\_Approval\\_Summary.pdf](http://www.mhsoac.ca.gov/Innovation/docs/InnovationPlans/Butte_INN_Approval_Summary.pdf)

<sup>55</sup> <http://www.fresnobee.com/2012/07/30/2929985/fresno-hmong-garden-praised.html#storylink=cpy>

<sup>56</sup> <http://www.buttecounty.net/Behavioral%20Health/Mental%20Health%20Services%20Act%20-%200Id/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Housing/HmongFocusGroupDataResults.aspx>

<sup>57</sup> <http://www.buttecounty.net/Behavioral%20Health/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/12-13%20Annual%20Update%20Narrative%20DRAFT%201.aspx>

and  
<http://www.buttecounty.net/Behavioral%20Health/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/BH1213MHSAPlanUpdateplan.aspx>

<sup>58</sup>  
<http://www.buttecounty.net/Behavioral%20Health/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/MHSA%20Benefits%20to%20Butte%20County.aspx>

<sup>59</sup>  
[http://64.166.146.155/agenda\\_publish.cfm?mt=ALL&get\\_month=10&get\\_year=2012&dsp=agm&seq=12398&rev=0&ag=238&ln=23705&nseq=12400&nrev=0&pseq=&prev=#ReturnTo23705](http://64.166.146.155/agenda_publish.cfm?mt=ALL&get_month=10&get_year=2012&dsp=agm&seq=12398&rev=0&ag=238&ln=23705&nseq=12400&nrev=0&pseq=&prev=#ReturnTo23705)

<sup>60</sup> The "purpose" of the hip-hop car was to help at-risk children learn life skills that will make them productive citizens, by promoting educational and vocational opportunities any by providing training, support and other tools they need to overcome challenging circumstances." That may be worthy, but is outside the purpose and intent of MHSA which is to help people with serious mental illness. [http://66.39.42.45/services/mental\\_health/prop63/pdf/pei\\_agencies\\_descriptions.pdf](http://66.39.42.45/services/mental_health/prop63/pdf/pei_agencies_descriptions.pdf) and [http://www.contracostatimes.com/top-stories/ci\\_18356480](http://www.contracostatimes.com/top-stories/ci_18356480)

<sup>61</sup> [http://www.mhsoac.ca.gov/MHSAOC\\_Publications/docs/PressReleases/2011/PEITrendsReport\\_05-11-11.pdf](http://www.mhsoac.ca.gov/MHSAOC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf)

<sup>62</sup> To "prove" it works the county notes, "Fifty-two students were enrolled in New Leaf last year. Of these, 71% of students improved their attendance; 78% earned the necessary academic credits at or above grade level; and 77% achieved at least 4 out of 6 individual goals." That is likely true. But improving school attendance, helping people get through high school are not the purpose of MHSA. [http://library.constantcontact.com/download/get/file/1109615552347-349/CalMHSA\\_Contra\\_Costa\\_FINAL.pdf](http://library.constantcontact.com/download/get/file/1109615552347-349/CalMHSA_Contra_Costa_FINAL.pdf)

<sup>63</sup> This is a social service program designed "to reverse the impact of discrimination, strengthen families and build community." But the purpose of MHSA is to help people with mental illness. [http://library.constantcontact.com/download/get/file/1109615552347-349/CalMHSA\\_Contra\\_Costa\\_FINAL.pdf](http://library.constantcontact.com/download/get/file/1109615552347-349/CalMHSA_Contra_Costa_FINAL.pdf)

<sup>64</sup> It would, perhaps, arguably, be appropriate to have specialized (rather than mainstreamed) mental illness services for members of the LGBTG community, but there is no indication the services being provided by the county are for those with mental illness.

- **Fresno County** used MSHA funds for
  - What stakeholders wanted, even when inconsistent with the legislation and it prevents programs for seriously mentally ill from being funded.<sup>65</sup>
  - To expand outpatient services for children who are not seriously emotionally disturbed (\$750,000).
  - Community Garden (\$40,000)<sup>66</sup>
  
- **Imperial County** used MSHA funds
  - For people experiencing trauma, child or domestic abuse, chronic neglect, enduring deprivation and poverty, homelessness, violence (personal or witnessed), racism and discrimination, intergenerational or historical trauma, the experience of refugees fleeing war and violence, loss of loved ones, and natural and human disasters.<sup>67</sup>
  
- **King County** spends MSHA funds
  - on children in “stressed families”.<sup>68</sup>
  - on youth reading below grade level.<sup>69</sup>
  - RESTATE. This is an \$800,000 program operated jointly with Tulare County and alternatively describe as a stigma and discrimination reduction program or a suicide prevention program.<sup>70</sup> It is basically an arts project that lets kids create a PSA. It is based on “Mental Health First Aid, a non-evidence based highly criticized approach.”<sup>71</sup>
  
- **Los Angeles** (Also see “The Failed Stakeholder Process: LA County as Case Study”<sup>72</sup>) Los Angeles is using MSHA funds for
  - Triple P Parenting Skills<sup>73</sup> is being funded on Los Angeles, Shasta, and other counties. It is designed to reduce child abuse. In addition to not being a mental illness program, extensive research has been published showing Triple P is ineffective.<sup>74</sup>

<sup>65</sup> (Behavioral Health Director) “Thornton said he would like more of the Mental Health Services Act money to treat people with severe mental illness. With county budgets tight, he said, the priorities should be “crisis first, treatment and then early intervention, prevention. Evans said the county plan isn’t perfect, but it is a compromise between what the community wants and what the staff sees as gaps in the system “It’s all a compromise,” she said. The quote appeared in the January 6, 2013 Fresno Bee formerly available at <http://www.fresnobee.com/2013/01/06/3124110/fresno-county-mental-health-projects.html> (accessed 1/7/13)

<sup>66</sup> “The county would add a seventh community garden to six already in operation at a cost of about \$40,000.” The quote is believed to be from the January 6, 2013 Fresno Bee formerly available at <http://www.fresnobee.com/2013/01/06/3124110/fresno-county-mental-health-projects.html> (accessed 1/7/13) What is especially disturbing is that funding gardens in lieu of services for people with mental illness, had already come under public scrutiny at this time. However the commissioner was not worried about being audited. “Taylor said she wouldn’t be concerned if the state audited the gardens. But that is unlikely to happen, because the state selected three counties to review, and Sacramento County was chosen in the Central Valley, she said.

<sup>67</sup> “Trauma” is common. Everyone loses a loved one. Funds may not be spent to ‘reduce trauma’ however, they may be spent to treat PTSD if that occurs.

[http://www.mhsoac.ca.gov/MHSOAC\\_Publications/docs/PressReleases/2011/PEITrendsReport\\_05-11-11.pdf](http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf)

<sup>68</sup> [http://www.co.kern.ca.us/artman2/kcmh/uploads/1/1MMSA\\_Update\\_Cover\\_12-13post3.pdf](http://www.co.kern.ca.us/artman2/kcmh/uploads/1/1MMSA_Update_Cover_12-13post3.pdf)

<sup>69</sup> This was funded with Innovative funds. Innovative Services funds must have a nexus to the overall intent of MSHA to help people with serious mental illness. Few who are reading below grade level will develop a “serious mental illness”. Improving reading does not “prevent mental illness from becoming severe and disabling.” It is a classic example of a worthy social service program masquerading as a mental illness program in order to access funds not intended for them.

[http://mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/INN\\_Kings\\_020911.pdf](http://mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/INN_Kings_020911.pdf)

<sup>70</sup> <http://www.sptf.org/english/index.cfm/programs/restate/> and [http://www.hanfordsentinel.com/news/local/programs-target-teen-suicide-mental-health/article\\_bd82bf6e-63f4-11e2-9d10-001a4bcf887a.html](http://www.hanfordsentinel.com/news/local/programs-target-teen-suicide-mental-health/article_bd82bf6e-63f4-11e2-9d10-001a4bcf887a.html)

<sup>71</sup> We have seen no evidence it helps persons with serious mental illness, although no doubt the kids enjoy creating the PSAs and the arts departments of the participating schools appreciate the additional funding. The website alludes to the fact that this is part of the Mental Health First Aid USA, a commercially available program distributed by various non-profits. Mental Health First Aid is non-evidence based. Thirty six of the 55 peer reviewed articles on Mental Health First Aid were authored or co-authored by the vendors of the approach. A 2005 study of Mental Health First Aid found “There has not yet been an evaluation of the effects on those who are the recipients of the first aid” and acknowledged, “Perhaps the most important unanswered question is the benefits of being a recipient of MHFA” Mental Health First Aid does not appear on SAMHSA’s National Registry of Evidence Based Practices.

<sup>72</sup> In other budget documents, LA County claims to have spent \$80 million on housing for seriously mentally ill. We would be interested in, but did not have time to determine, if any of the promised housing was built or- to ascertain the diagnosis of those provided housing. See <http://www.hacla.org/en/cms/7931/>

<sup>73</sup> <http://www.redding.com/news/2012/nov/08/shasta-county-child-abuse-rate-climbs-twice-state/>

<sup>74</sup> Thirty two of the thirty three studies purporting to show it works were by the same people who created the program. A meta study “found no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term. The ‘evidence’ for it turned out to lack validity. See “Triple P-Positive Parenting programs: the folly of basing social policy on underpowered flawed studies” published in BMC. Available via NIMH at <http://www.ncbi.nlm.nih.gov/pubmed/23324495>. Also see “How evidence-

**Case Study: Laura's Law a Good Program Being Funded with PEI Funds in Los Angeles.**

While this appendix lists inappropriate spending, we do note that Los Angeles has a tiny pseudo-Laura's Law program being very appropriately funded with MHSA funds. LA should expand this program by cutting the misspending identified above. Using their version of Laura's Law, Los Angeles reduced incarceration of people with the most serious mental illnesses 78%; reduced hospitalization 86%; and reduced hospitalization 77% even after discharge from Laura's Law. (<http://lauras-law.org/states/california/lauraslawlosangelesstudy>).

- "emotional recovery" centers, "stigma" campaigns, tuition reimbursement programs, market research, employment offices<sup>75</sup>
- Student 'well-being' massage chairs, Zumba classes, a meditation room and a biofeedback lab (\$230,000)<sup>76</sup>
- Populations that may or may not have mental illness such as Children/youth at risk for school failure and children/youth at risk of or experiencing juvenile justice involvement<sup>77</sup>
- Free Your Mind Radio Show<sup>78</sup>
- Unsuccessful employment training programs<sup>79</sup>
- **Marin County** is using MHSA funds for
  - Teen Screen.<sup>80</sup> Teen screen has proven to be ineffective at reducing teen suicide.<sup>81</sup>
  - Triple P Parenting.<sup>82</sup> See discussion under Los Angeles County for lack of evidence program is effective.
- **Merced County** is using MHSA funds for
  - To host a Halloween event at Yosemite Lake, a Multicultural Celebration, Thanksgiving Lunch, Winter Celebration, Cinco de Mayo Celebration, Black History Month, the Hmong Harvest Celebration and... Mental Health Month Picnic at the Lake.<sup>83</sup>
  - Caring Kids.<sup>84</sup> It teaches skills to parents of children 0 – 5 years old. Funding the program with mental health dollars is almost offensive because it suggests parents cause mental illness and that by teaching parents skills they will not cause the mental illness.<sup>85</sup>
- **Nevada County** uses MHSA funds for

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based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P." available via NIMH at <http://www.ncbi.nlm.nih.gov/pubmed/23121760>. See meta-study at <http://www.biomedcentral.com/content/pdf/1741-7015-10-130.pdf>

<sup>75</sup> These arguably benefit the least "severely" ill but inarguably don't benefit the most "severely" ill

[http://ceo.lacounty.gov/ccp/mhsa\\_pei.htm#GI](http://ceo.lacounty.gov/ccp/mhsa_pei.htm#GI)! And

<http://lacdmh.lacounty.gov/News/Publications/Enews/Documents/APR1411ENEWS.html>

<sup>76</sup> [http://blogs.laweekly.com/informer/2012/07/california\\_tax\\_for\\_mentally\\_ill\\_massage\\_chairs\\_zumba\\_social.php](http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_social.php) and

[http://www.namicalifornia.org/uploads/eng/mhsa\\_full\\_report.pdf](http://www.namicalifornia.org/uploads/eng/mhsa_full_report.pdf)

<sup>77</sup> <http://www.freeyourmindprojects.com/static-pages/about-us/#.UDTo044Zy70>

<sup>78</sup> It allows recipients of MHSA funding to go on radio to say how important their work is. In the promo materials, they readily admit this is for the 'one in four' who have mental health issues, rather than the 5-9% with serious mental illness identified as being a priority population in MHSA legislation (who would be hard to reach by radio shows).

<sup>79</sup> At an MHSOAC board meeting a Los Angeles FSP Program Manager admitted the L.A. job training program had only increased employment days 4.2 percent and that was mainly due to government creating jobs versus any private sector jobs being created. See <http://lacdmh.lacounty.gov/News/Publications/Enews/Documents/APR1411ENEWS.html> and [http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf)

<sup>80</sup> <http://www.co.marin.ca.us/depts/HH/main/mh/mh/MHSA%20PEI%20fund%20shift%20to%20Prudent%20Reserve%20June%202012.pdf>

<sup>81</sup> "On 15 November, TeenScreen, a program to detect depression in young people, announced on its website: "The National Center will be winding down its program at the end of this year. The center did not give a reason for the closure of its multimillion dollar project, nor did anyone from TeenScreen respond to inquiries by the BMJ. Critics of the program said that the test had not been proven to reduce suicides and that an analysis by its inventor, David Shaffer, showed that the computer based screening test had a positive predictive value of only 16%. Direct and indirect ties between the drug industry and TeenScreen fueled the concerns of critics that the program would inevitably cause more children, including preschoolers, to be treated with antidepressant drugs."

<http://www.bmj.com/content/345/bmj.e8100>

<sup>82</sup> <http://www.co.marin.ca.us/depts/HH/main/mh/mh/MHSA%20PEI%20fund%20shift%20to%20Prudent%20Reserve%20June%202012.pdf>

<sup>83</sup> [http://www.co.merced.ca.us/pdfs/mentalhealth/mh/mh/mhsa\\_annual\\_update\\_2012\\_2013.pdf](http://www.co.merced.ca.us/pdfs/mentalhealth/mh/mh/mhsa_annual_update_2012_2013.pdf)

<sup>84</sup> <http://blogs.webmd.com/childrens-health/2012/08/study-links>

<sup>85</sup> The program claims to have made the following positive impacts, not having to do with preventing serious mental illness. "Parents, Child Care Providers, and Teachers have learned new ways to manage children's behavior. Our support groups have helped parents learn new parenting skills. Parents have learned about how children grow. Parents have learned better ways to discipline their children. Parents have learned to share experiences and feelings with other parents. Parents have learned about information on community resources and services. Parents have learned to take better care of themselves. Parents have learned better ways to handle stress. Child Care Providers have learned new ways to promote attachment and bonding."

**Case Study: Laura's Law: A good program in Nevada County** By using MHSA funds to allow individuals under court orders access to existing programs Nevada County served the most seriously mentally ill and decreased number of Psychiatric Hospital Days 46.7%; number of Incarceration Days 65.1%, number of Homeless Days 61.9%; number of Emergency Interventions 44.1%. Laura's Law implementation saved \$1.81-\$2.52 for ever dollar spent and "receiving services under Laura's Law caused a reduction in *actual* hospital costs of \$213,300 and a reduction in *actual* incarceration costs of \$75,600 (<http://lauras-law.org/states/california/lresultsin2counties.html>)

- **Orange County** is using MHSA funds
  - Wellness Centers specifically for those "who have achieved a high level of recovery," Groups to improve "personalized socialization," relationship building, and exploring educational opportunities.<sup>86</sup>
  - Teen Screen, an ineffective teen suicide program. See Marin County for a discussion of Teen Screen.
  - High end annual report with no data on where the money went.<sup>87</sup>
  
- **Placer County** received numerous critical comments about their use of MHSA funds for social services masquerading as mental illness programs. They did not address them.<sup>88</sup> MHSA uses MHSA funds for
  - "Youth Council: What is Success Video Project"<sup>89</sup>.
  - "Ready for Success: Incredible Years", and "Parent Project."<sup>90</sup> These programs allegedly strengthen parenting competencies but are not related to mental illness. It is now well established that having bad parents does not cause serious mental illnesses like schizophrenia and bipolar disorder.
  - "Positive Indian Parenting"<sup>91</sup>
  - "Native Youth Development Program"
  - To "prevent mental illness".<sup>92</sup> No one knows how to do that.
  - Native Culture Camps
  - "Life Skills Training", a substance abuse prevention program<sup>93</sup>. Substance abuse programs (except for those with mental illness) were specifically excluded from the MHSA Legislation.<sup>94</sup>
  - "Teaching Pro Social Skills" teaches kids about teasing, embarrassment, and expressing feelings.<sup>95</sup>
  - Adventure Risk Challenge (ARC) a literacy program.<sup>96</sup>
  - "What is Success" Video Project "to send the message to Middle and High School students that everyone has the ability to choose what success means to them and that it is never too late to start working towards your own goals."<sup>97</sup>
  
- **Riverside County** is using MHSA funds for
  - Parenting Program for Latina mothers (\$2,958,317).<sup>98</sup>

<sup>86</sup> <http://ochealthinfo.com/docs/newsletters/recoveryconnection/2008-2010-RecoveryConnection.pdf>

<sup>87</sup> [http://ochealthinfo.com/docs/behavioral/mhsa/Resources/Reports/MHSA\\_5\\_Year\\_Booklet\\_WEB.pdf](http://ochealthinfo.com/docs/behavioral/mhsa/Resources/Reports/MHSA_5_Year_Booklet_WEB.pdf)

<sup>88</sup> Ex. Dr. Frank Lozano asked for "hard data" for number of individuals seen/program and the results of their time spent under the guidance of Placer Mental Health". He also noted several programs were social services programs. Gayle Smullen of NAMI Placer County reported on the lack of programs for people with serious mental illness, and the preponderance of social service programs for non mentally ill being funded with Placer County MHSA funds. He did not receive an adequate response. Sharen Neal of Placer County NAMI noted that Placer county focused its PEI resources on children, when serious mental illness does not manifest itself until teens and twenties. Focusing on children left those most likely to develop mental illness least likely to be served. The response of Placer County authorities was inadequate, avoided the issue, and frequently blamed the Oversight Commission for the problems by saying they were due to their direction. See last pages of comments at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

<sup>89</sup> Page 11 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

<sup>90</sup> Page 7 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

Note that a large percentage of parents dropped out of the program.

<sup>91</sup> Page 8 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

<sup>92</sup> <http://www.sierrasun.com/article/20120625/COMMUNITY/120629945/1066&ParentProfile=1051>

<sup>93</sup> <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

<sup>94</sup> September 22, 2012 MHSA Board Minutes, MHSAOC "Commissioner Horn commented that ...the reason co-occurring disorders were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition" He then went on to express the importance of doing it anyway. This program is the result of that thought process. Minutes of MHSAOC Board Meeting September 22, 2011. Available at

[http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf) Accessed 6/24/12

<sup>95</sup> Page 10 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

<sup>96</sup> <http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf>

<sup>97</sup> <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

<sup>98</sup> While a worthy program, there is no evidence that serious mental illness is caused by parents (other than possibly genetically).

Attaching the word 'mood' or "mental" to a program does not turn a program that helps people with mental illness.

[http://blogs.laweekly.com/informer/2012/07/california\\_tax\\_for\\_mentally\\_ill\\_message\\_chairs\\_zumba\\_social.php](http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_message_chairs_zumba_social.php)

- **Sacramento** is using MHSA Innovation Funds to
  - Provide "culturally sensitive help to all generations" (United Lu-Mien)<sup>99</sup>. Not a mental illness program.<sup>100</sup>
  - Reduce Bullying<sup>101</sup>
  - Reduce Violence<sup>102</sup>
  - Increase Social Connectedness<sup>103</sup>
  - Help 12-26 year olds "to gain positive, proactive, successful life skills"<sup>104</sup>
  - "To improve the well being of caregivers" (Del Oro Caregiver Resource Center<sup>105</sup>). The caregivers being helped are caregivers for persons with dementia, not mental illness
  - Reduce stigma and promote mental health in population not identified by MHSA<sup>106</sup>
  - Capital Adoptive Families<sup>107</sup>. This organization supports adoptive parents and does not have the tight nexus to helping people with serious mental illness.
  - "Strengthening Families Project". Within this program are "Quality Child Care Collaborative", "HEARTS for Kids", "Bullying Prevention Education and Training", "Early Violence Intervention Begins With Education" and "Independent Living Program 2.0". When presented at the May Mental Health Board meeting a participant correctly noted these were social services programs and ineligible for MHSA funding. They were told, "when the public hearing were held on these programs, the community wanted them"<sup>108</sup>
- **San Bernardino County** is using MHSA Funds to
  - Reduce teen prostitution \$895,000.<sup>109</sup>
  - Acupuncture and acupressure, teach art classes, equine therapy, tai-chi and zumba to the general public; and an LGBT prom.<sup>110</sup>
  - Interagency Youth Resiliency Team.<sup>111</sup> It "employs former foster and probation youth to serve as mentors to "system involved" youth ages 13 - 21."<sup>112</sup>
- **San Diego** is using MHSA funds<sup>113</sup>
  - To reduce gang violence
  - Triple P Parenting Program, a program proven unsuccessful at reducing child abuse
  - "Reaching Out", a program for those with Alzheimer's
- **San Francisco** is using MHSA funds
  - for yoga, line dancing and drumming.<sup>114</sup>
  - 90 minute movie about mental health (not mental illness).<sup>115</sup> It was shown at a community center and funded

<sup>99</sup> <http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html>

<sup>100</sup> We could not find the term "mentally" or "mental" used once. This suggests to us the funds will not be used for mentally ill.

<sup>101</sup> Page 23 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

<sup>102</sup> Page 27 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

<sup>103</sup> Page 24 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

<sup>104</sup> Page 27 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

<sup>105</sup> <http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html>

<sup>106</sup> Page 28 has a 'mental health promotion' project that features a web site <http://www.stopstigmatasacramento.org>. Note that the site addresses the 1 in four with mental health issues. But MHSA has specific language saying it is not for one in four (25%) of population, it is only for the 9% with the most serious mental illnesses. It also includes info designed to minimize and confuse the public about the incidence of violence. <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

<sup>107</sup> <http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html>

<sup>108</sup> Reported to us by an attendee who requested anonymity.

<sup>109</sup> <http://www.sbcounty.gov/dbh/Announcements/2010/Innovation%20Plan%20Final%202-8-10.pdf>

<sup>110</sup> [http://blogs.laweekly.com/informer/2012/07/california\\_tax\\_for\\_mentally\\_ill\\_massage\\_chairs\\_zumba\\_socal.php](http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_socal.php)

<sup>111</sup> <http://www.marketwatch.com/story/foster-youth-prepares-for-adulthood-with-help-from-new-mentor-program-from-emq-familiesfirst-2012-11-18>

<sup>112</sup> That is a worthy social service program, but it is not a program that reduces the duration of untreated mental illness or prevents mental illness from becoming severe and disabling. The PR announcement for it does not mention mental illness or mental health (except to state MHSA funds are being used for it) A PowerPoint explaining who IYRT serves is at [http://emqff.org/about/docs/FY12\\_agency-wide\\_report\\_pp\\_final.pdf](http://emqff.org/about/docs/FY12_agency-wide_report_pp_final.pdf). Page 8, shows that only 2% of the population they serve have psychotic disorders (serious mental illness)

<sup>113</sup> <http://sandiego.camhsa.org/files/PEI-Prg-Serv-Summ-Current.pdf>

<sup>114</sup> [http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/FY11\\_12AnnualPlanUpdate\\_03012011.pdf](http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/FY11_12AnnualPlanUpdate_03012011.pdf)

by MHA/SF, a large recipient of MHSA funds. MHA/SF Exec. Dir. Is on the Oversight Commission. While videos and movies are fun to make it is hard to see how making these movies should trump delivering services to people with mental illness.

- **San Luis Obispo County** uses MHSA funds for
  - employment programs <sup>116</sup>
  - To help “Tens of thousands” rather than people with serious mental illness. <sup>117</sup>
- **Shasta County** is using MHSA funds for
  - A Gatekeeper program to improve services for the elderly. <sup>118</sup>
  - Triple P Parenting program. See “Los Angeles” County above for information showing Triple P has no scientific basis and is unproven. Shasta is a good example of how the stakeholder process was used to gain funding for this program in spite of its lack of efficacy. <sup>119</sup>
  - Reducing “Adverse Childhood Experiences” <sup>120</sup>
- **Stanislaus County** is using MHSA funds for
  - “Arts for Freedom” <sup>121</sup> an art show for people who want to display their art.
  - Stanislaus considered a good program, but we don’t know if they ever followed through on it. *“Stanislaus County officials are talking with local hospitals about forming crisis teams to stabilize patients who are considering suicide or having psychotic symptoms. The units with staff able to prescribe medication would choose people with the best chances of being stabilized, so they can return home and not be admitted to Doctors Behavioral Health Center on Claus Road.”* <sup>122</sup>
- **Tehama County is using MHSA funds for**
  - Teen Screen, an ineffective program designed to reduce teen suicide <sup>123</sup>
  - Drumming Circles <sup>124</sup>
- **Tulare County** used MHSA funds for
  - farming webinar for dairy farmers who, due to the current economic state, are experiencing a downturn in milk prices. <sup>125</sup>
  - RESTATE. This is an \$800,000 program operated jointly with King County and alternatively describe as a stigma and discrimination reduction program or a suicide prevention program. See discussion under King County on this being an ineffective non-evidenced based program that seems to move MHSA funds from helping persons with mental illness to funding school art departments.

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<sup>115</sup> <http://www.mentalhealthsf.org/programs/solve/>

<sup>116</sup> They are not for people who have mental illness, but are for “Transitional Age Youths” (TAYs) The County justifies the expenditures by claiming the groups are underserved in the County; they are likely to have experienced numerous traumatic events and be vulnerable to developing mental illness, substance abuse, *domestic violence, homelessness, criminal activity, and unemployment*. Trauma (losing a loved one, seeing something untoward) happens to many people and rarely ever results in a mental illness.

[http://www.mhsoac.ca.gov/MHsoac\\_Publications/docs/PressReleases/2011/PEITrendsReport\\_05-11-11.pdf](http://www.mhsoac.ca.gov/MHsoac_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf)

<sup>117</sup> The director of Behavioral Health in SLO claims MHSA is helping tens of thousands in her county.

<http://www.sanluisobispo.com/2011/07/12/1680175/viewpoint-our-mentally-ill-deserve.html>

<sup>118</sup> <http://www.redding.com/news/2012/nov/07/senior-living-gatekeeper-program-keeps-eye-out/>

<sup>119</sup> Shasta County claims that Triple P got on the list of funded programs because “During MHSA’s stakeholder input process, community members ranked children and youth in stressed families as the #1 population to work with in preventing mental illness”. It is true that reducing stress in families of people with mental illness can improve the course of outcome. However, there is no science that says stress causes mental illness, or reducing stress in families of people without mental illness lowers the incidence of mental illness. This is a worthy social service program masquerading as a mental health program to access MHSA

funds. [http://media.redding.com/media/static/Annual\\_Report\\_7th\\_FINAL.pdf](http://media.redding.com/media/static/Annual_Report_7th_FINAL.pdf). See description of Triple P under LA County.

<sup>120</sup> <http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/ShastaPEIPlan.pdf> and

[http://media.redding.com/media/static/Annual\\_Report\\_7th\\_FINAL.pdf](http://media.redding.com/media/static/Annual_Report_7th_FINAL.pdf)

<sup>121</sup> [http://www.stanislausmhsa.com/pdf/public/INN%20Project%20Brief%20Descriptions%20Posted\\_8.25.11.pdf](http://www.stanislausmhsa.com/pdf/public/INN%20Project%20Brief%20Descriptions%20Posted_8.25.11.pdf) and

<http://www.modbee.com/2012/04/25/2173965/county-promotes-mental-health.html>

<sup>122</sup> <http://www.modbee.com/2012/11/11/2451993/stanislaus-county-mental-health.html> We don’t know if this was ever implemented or if merely exists in press release form.

<sup>123</sup> [http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/PEI\\_Tehama\\_Final\\_2-1-10.pdf](http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/PEI_Tehama_Final_2-1-10.pdf). See Marin County for Teen Screen discussion.

<sup>124</sup> <http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf>

<sup>125</sup> [http://www.mhsoac.ca.gov/MHsoac\\_Publications/docs/PressReleases/2011/PEITrendsReport\\_05-11-11.pdf](http://www.mhsoac.ca.gov/MHsoac_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf) (Page 14)

## Full Service Partnerships: \$2.5 billion unaccounted for

**Background:** MHSA was intended to expand successful existing programs.<sup>126</sup> Full Service Partnerships (FSP) were not an existing program and do not appear in California law or MHSA legislation. After Proposition 63 passed, the California Department of Mental Health created a broad definition of them:

*“the collaborative relationship between the County and the client, and when appropriate the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.”<sup>127</sup>*

FSPs are colloquially described as “doing whatever it takes”, albeit only for voluntary patients. As a result of direction to spend money on FSPs,<sup>128</sup> \$2.5 billion went to FSPs instead of existing programs that had already proven their effectiveness.<sup>129</sup> FSPs are serving some people with serious mental illness and doing a good job. FSPs are only voluntary, and therefore exclude many of the most seriously ill, like those who are psychotic. No information is collected or reported on the diagnosis of those being served. It is unclear how many of the individuals in FSPs have serious mental illnesses like schizophrenia or bipolar disorder or if FSPs are better than the existing programs that failed to receive funding as a result of the prioritization of FSPs.

### Problems

#### 1. Zero oversight to ensure people enrolled in FSPs have schizophrenia, bipolar disorder or other serious mental illness.

The Oversight Commission collects extensive information on age, ethnicity, sexual orientation of FSP enrollees, but not diagnosis.<sup>130</sup> Thus, there is no way to know whether the \$2.5 billion FSP initiative is serving people with serious mental illness as required by the legislation.

Partially in response to growing public concerns, MHSOAC did contract with UCLA, a large recipient of MHSA funds for a report on FSPs.<sup>131</sup>

- Before releasing the report, at the request of the commission and others, the UCLA authors amended the supposedly independent report to “focus on positive outcomes”.<sup>132</sup>
- The report intentionally and knowingly overstated cost savings from incarceration by allocating fixed costs (which do not change due to number of people served) to each patient and calculating it as savings.<sup>133</sup>
- In order to “prove” FSPs save money, the UCLA authors added ‘physical health’ savings--a welcome, secondary, but not primary goal of MHSA, and a goal that can be readily achieved by serving people with physical illnesses rather than serious mental illnesses.
- The report recommended more studies be conducted the result of which would send more money to programs associated with the commissioners.
- The UCLA report did not include any information of diagnosis of participants.
- The UCLA report did not reveal the multiple regulations that make many of the most seriously mentally ill ineligible for FSP services or that FSPs were only serving those well enough to volunteer.

<sup>126</sup> “The legislature found “By expanding programs that have demonstrated their effectiveness, California can save lives and money” (Findings and Declarations (f)). The Purpose and Intent of the law was “To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California”

<sup>127</sup> Emergency regulation in Cal. Admin. Code tit. 9, § 3200.130

<sup>128</sup> Because FSPs were an unproven new program it might have been appropriate to spend Innovative Funds on them. 5% of MHSA funds are set aside for Innovative New Programs. Instead, massive general funding was mandated to be used. See direction at <http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf>

<sup>129</sup> MHSOAC allocated 51% of all CSS funds which are 50% of all MHSA funds to them, making FSPs the largest MHSA expenditure. If MHSA raised \$10 billion since inception, \$2.5 billion were spent on FSPs.

<sup>130</sup> Diagnosis information would be available via MediCal or anonymized questionnaires.

<sup>131</sup> “Full Service Partnerships: California’s Commitment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Serious Mental Illness” prepared by UCLA Center for Healthier Children, Youth and Families (10/31/12). Available at [http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC\\_111512\\_Tab4\\_MHSA\\_CostOffset\\_Report\\_FSP.pdf](http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf)

<sup>132</sup> See page 4 of UCLA Report.

<sup>133</sup> See discussion by Commissioner Brown (who represents law enforcement on the commission) starting on page 16 of November 2012 Oversight Commission Board meeting minutes. Among other comments, Commissioner Brown noted the use of fixed versus variable costs and correctly stated, “(T)hat that is not an accurate measure of cost savings and may taint the rest of the report in terms of what savings are achieved. This report will be open to criticism regarding the types of cost savings indicated. Additionally, there is a disparity where Los Angeles used a figure of over \$1,000 a day when every other county used a figure substantially lower.”

“Available at [http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC\\_012413\\_Tab1\\_Minutes111512.pdf](http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_012413_Tab1_Minutes111512.pdf)

Oversight Commissioners used the UCLA report to declare their stewardship of FSP programs a success.

## **2. FSPs exclude many of the most seriously ill. They only serve those well enough to recognize they are ill.**

Regulations were issued that required MHSA funded programs to be designed for voluntary patients only.<sup>134</sup> This made the most seriously ill ineligible for FSPs. Up to 40% of those with bipolar disorder and 50% of those with schizophrenia are so ill, they don't know they are ill (anosognosia).<sup>135</sup> For example, a homeless person yelling they are the Messiah, or screaming the FBI planted a transmitter in their head would not likely be well enough to volunteer for services. These individuals are excluded from FSPs. Doing 'whatever it takes', should extend to helping people who lack awareness of their illness.<sup>136</sup> See Appendix D flow charts show the steps programs are skipping when determining if someone qualifies for MHSA-funded support.<sup>137</sup>

## **4. To fund FSPs, programs that that help people with serious mental illness who are homeless were left unfunded.**

Proponents of Full Service Partnerships claim FSPs are referred to in MHSA because the Finding and Declarations reference AB 34 programs.<sup>138</sup> The population served by AB 34 Existing Systems of Care programs are "**severely mentally ill** adults who are **homeless, recently released from a county jail or state prison**, or otherwise at risk of homelessness or incarceration."<sup>139</sup> There is no indication FSPs are serving the same population as AB-34 programs. In fact, since 2007, "the proportion of prison inmates with mental illnesses has grown from 19 percent in 2007 to 26 percent now".<sup>140</sup>

AB 34 programs reduced the number of consumers hospitalized, 42.3%; number of hospital admissions, 28.4%; number of hospital days, 55.8%; number of consumers incarcerated, 58.3%; number of incarcerations, 45.9%; number of incarceration days, 72.1%; number of consumers who were homeless, 73%; and many other barometers of success.<sup>141</sup> They deserve equal or better funding than FSPs.

## **4. The FSP model may help higher functioning get housing but is least successful at helping people with schizophrenia and bipolar disorder get housing—the two most serious mental illnesses.**<sup>142</sup>

### **Conclusion:**

\$2.5 billion is spent on FSPs without any oversight of whether they are serving eligible individuals. FSPs exclude many of the most seriously ill.

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<sup>134</sup> CCR Title 9 Regulation 3400(b)

(b) Programs and/or services provided with MHSA funds shall... (2) be designed for voluntary participation" While the regulation went on to state, "No person shall be denied access based solely on his/her voluntary or involuntary status" the use of MHSA funds to prevent implementation of Laura's Law has obviated that option.

<sup>135</sup> See anosognosia at <http://mentalillnesspolicy.org/medical/anosognosia-studies.html>

<sup>136</sup> One way around this conundrum would be for counties to implement Laura's Law.

<sup>137</sup> Flow charts: Impact of the Full Service Partnership Programs on Independent Living. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley May 2010

<sup>138</sup> Findings and Declarations (b): A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health<sup>138</sup>. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come.

<sup>139</sup> Legislative analysis at [http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab\\_0001-0050/ab\\_34\\_cfa\\_19990816\\_185010\\_sen\\_comm.html](http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0001-0050/ab_0001-0050/ab_34_cfa_19990816_185010_sen_comm.html)

<sup>140</sup> Associated Press. California Mental Health Dollars Bypass Mentally Ill, July 28, 2012 as published in Sacramento Bee.

<sup>141</sup> <http://www.homebaseccc.org/PDFs/CATenYearPlan/CAHighlightOutreach.pdf>

<sup>142</sup> Schizophrenia and bipolar disorder are two of the most serious mental illnesses. The housing initiatives funded by MHSA help people with those disorders the least. "The Impact of the Full Service Partnership Programs on Independent Living found "not having schizophrenia or bipolar disorder" led to increased likelihood of independent living." Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley. "The Impact of the Full Service Partnership Programs on Independent Living: A Markov Analysis of Residential Transitions" Petris Report # 2010-3. Available at [http://www.dmh.ca.gov/Prop\\_63/MHSA/Publications/docs/3\\_Petris\\_Residential\\_Report\\_Final.pdf](http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/3_Petris_Residential_Report_Final.pdf)

# Insider Dealing: \$23 million diverted to organizations associated with Oversight Commission

## Summary

Over \$23 million in Mental Health Services Act (MHSA) funds are going to organizations currently or formerly run by those responsible for oversight of the expenditures. This may be a violation of California's conflict-of-interest laws and raises questions about whether MHSA funds are being spent appropriately. Some of the funds are being used to prevent people with serious mental illness from receiving treatment.

## Background

Proposition 63 established the MHSA fund to provide services to individuals with "serious mental illness" and prevent those "with mental illness" from having it become "severe and disabling". Proposition 63 also established the Mental Health Services Oversight and Accountability Commission (Oversight Commission) to approve certain MHSA expenditures which are distributed by the Oversight Commission directly; or presented to them for approval as part of county mental health plans or via the California Mental Health Services Authority (CalMHSA), a Joint Power Authority that pools the resources of individual counties.

## Methodology

We examined the 2011 "Prevention and Early Intervention" (PEI) component of MHSA which represents 20% of overall MHSA funds. We did not look for potential insider dealing in the other 80% or in prior years. To determine who received PEI funds we examined the 2011 CalMHSA Funding Report which includes PEI grants by dollar amounts<sup>143</sup> and a list of PEI programs funded by MHSA which does not include dollar amounts.<sup>144</sup> We then went to the websites of the organizations that received the funds to determine who sat on their boards of directors and in key staff positions. Finally, we compared the boards and staff of fund recipients with the names of those who serve the oversight commission.<sup>145</sup>

## Findings

### Rusty Selix - \$5.92 million

Mr. Selix is on the MHSOAC Mental Health Funding and Policy Committee and Evaluation Committee<sup>146</sup>. During the period of the study, he was Executive Director of Mental Health America of California (MHAC)<sup>147</sup> MHSOAC commissioners approved one grant for \$3 million and another for \$2.92 million to MHA of San Francisco a chapter of MHAC. Other chapters of MHAC that had their grants approved by oversight commissioners include MHA Orange County (two grants); MHA LA (2 grants); MHA of SLO; and MHA Sutter-Yuba.

Mr. Selix is Executive Director of the California Council of Community Mental Health Agencies (CCCMHA).<sup>148</sup> CCCMHA members receive MHSA funds. (See Richard Van Horn, below.) Mr. Selix received \$681,758 in compensation from CCCMHA (per CCCMHA 2010 990 IRS form).

### Richard Van Horn - \$11 million

During the period of our study, Mr. Van Horn was the MHSOAC Vice-Chair<sup>149</sup> and on the board of California Council of Community Mental Health Agencies (CCCMHA) a trade association representing providers of community mental "health" services.<sup>150</sup> Rusty Selix is Executive Director and received \$681,758 in compensation. MHSOAC commissioners approved \$2 million to go to CCCMHA member Didi Hirsch Psychiatric Services. They approved \$9 million to be split between CCCMHA members Transitions Mental Health Association, Kings View Corporation and others. The MHSOAC commissioners approved grants for the following CCCMHA members: Anka Behavioral Health; Bonita House (2 grants); Buckelew Programs; Chamberlain's Mental Health Services; Edgewood Center for Children and Families; EMQ Families First (3 grants); Fred Finch Youth Center (2 grants); La Clinica de La Raza; Pacific Clinics (3 grants); Rubicon Programs; San Fernando Valley Community Mental Health Center; Seneca Center; Social Model Recovery Systems; and Tulare Youth Service Bureau.

Mr. Van Horn has also been President and Chief Executive Officer (CEO) of the Mental Health America of

<sup>143</sup> [http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC\\_072811\\_Tab3\\_CalMHSA\\_StatusReport.pdf](http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf) Accessed 7/23/13

<sup>144</sup> [http://www.namicalifornia.org/uploads/eng/mhsoac\\_full\\_report.pdf](http://www.namicalifornia.org/uploads/eng/mhsoac_full_report.pdf) Accessed 7/23/13

<sup>145</sup> While many of these grants were given out by counties and CalMHSA, all were required to be reviewed and approved by the Oversight Commissioners. In addition, counties and CalMHSA, are dependent on the commission to approve other grants they make which would give them an incentive to curry favor with the oversight commissioners.

<sup>146</sup> [http://www.mhsoac.ca.gov/Committees/docs/Charters/2012/MHFPC\\_Charter\\_2012.pdf](http://www.mhsoac.ca.gov/Committees/docs/Charters/2012/MHFPC_Charter_2012.pdf)

<sup>147</sup> [http://www.mhac.org/advocacy/key\\_leaders.cfm](http://www.mhac.org/advocacy/key_leaders.cfm) Accessed 7/23/13

<sup>148</sup> <http://www.cccmha.org/aboutus.html> Accessed 7/23/13

<sup>149</sup> [http://www.mhsoac.ca.gov/About\\_MHSOAC/Commissioner\\_Bios.aspx](http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx) Accessed 7/23/13.

<sup>150</sup> <http://www.cccmha.org/ourMembers.html>

Los Angeles<sup>151</sup> which received at least two grants. MHALA paid Mr. Van Horn \$111,175 (per 2009 990 IRS form) Mr. Van Horn is a member of the board of the Mental Health Association of California (See grants listed under Selix).

### **Eduardo Vega - \$2.9 million**

During the period of this report, Mr. Vega was an MHSOAC Commissioner. He is on the board of directors of Disability Rights California<sup>152</sup> a special interest law firm active in preventing counties from using Laura's Law, to help persons with serious mental illness<sup>153</sup>. DRC received a \$2.9 million grant approved by Mr. Vega and the other commissioners. Mr. Vega has served as the Executive Director of the Mental Health Association of San Francisco<sup>154</sup> that received two grants each in the \$3 million range for a total of almost \$6 million. Previously, he served as Associate Director of Project Return. Project Return received a MHSA grant.

### **Ralph Nelson Jr., M.D. - \$3 million**

Dr. Nelson is an MHSOAC Commissioner.<sup>155</sup> During the period of this report, he was president of the National Alliance on Mental Illness in California. NAMI CA received a \$3 million grant of MHSA funds. Local chapters of NAMI that received MHSA funding include NAMI Sonoma and NAMI Orange County. Other NAMI chapters run programs benefiting from MHSA funds including NAMI Butte; NAMI Riverside (2 programs); NAMI San Diego (3 projects); NAMI San Mateo (2 projects); NAMI Santa Cruz; NAMI Sonoma; NAMI Stanislaus (4 projects); NAMI Ventura (2 programs); and NAMI Amador (3 programs).

### **Delphine Brody and Sally Zinman - \$1.5 million**

During the period of this report, Delphine Brody and Sally Zinman were on numerous Oversight Commission committees.<sup>156</sup> Ms. Zinman founded and Ms. Brody was Director of Public Policy for the California Network of Mental Health Clients<sup>157</sup>. The Commissioners approved a grant of \$1.5 million to CNMHC.

Mr. Selix,<sup>158</sup> Mr. Vega,<sup>159</sup> Mr. Nelson, Ms. Brody, Ms. Zinman and their organizations have all lobbied against treatment for people with the most serious mental illnesses who are so ill they are not aware they are ill. They have played a role in preventing counties from implementing Laura's Law which helps prevent people with serious mental illness from becoming violent.

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<sup>151</sup> <http://www.mhala.org/board-volunteers.htm> Accessed 7/23/13

<sup>152</sup> [http://www.disabilityrightsca.org/about/board\\_bios.htm](http://www.disabilityrightsca.org/about/board_bios.htm) Accessed 7/23/13.

<sup>153</sup> <http://www.disabilityrightsca.org/OPR/PRAT2012/AB1421.pdf> Accessed 7/23/13.

<sup>154</sup> <http://www.mentalhealthsf.org/about-us/staff/> Accessed 7/23/13.

<sup>155</sup> [http://www.mhsoac.ca.gov/About\\_MHSOAC/Commissioner\\_Bios.aspx](http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx). Accessed 7/23/13.

<sup>156</sup> [http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC\\_2011MHSOACCommitteeMembers.pdf](http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf) Accessed 7/23/13

<sup>157</sup> [http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC\\_2011MHSOACCommitteeMembers.pdf](http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf) Accessed 7/23/13

<sup>158</sup> [http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw\\_12-26.html](http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html) Accessed 7/12/13

<sup>159</sup> [http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw\\_12-26.html](http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html) Accessed 7/12/13

## \$9 million going to prevent counties from implementing Laura's Law

**Background:** Laura's Law allows courts to order--after extensive due process- very narrowly defined individuals who have serious mental illness and a past history of violence, dangerous behavior or needless hospitalizations to stay in treatment as a condition of staying in the community. It is only available "in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others"<sup>1</sup> Laura's Law helps the most seriously ill patients. Many are so ill, they don't know they are ill and therefore refuse voluntary services.<sup>2</sup>

- After implementing Laura's Law with MHA funds, Nevada County Psychiatric Hospital Days decreased 46.7 percent; number of Incarceration Days decreased 65.1 percent, number of Homeless Days decreased 61.9 percent; number of Emergency Interventions decreased 44.1 percent. Laura's Law saved \$1.81-\$2.52 for every dollar spent. "Receiving services under Laura's Law caused a reduction in *actual* hospital costs of \$213,300 and *actual* incarceration costs of \$75,600".<sup>3</sup>
- In Los Angeles using MHA funds to implement Laura's Law reduced incarceration 78 percent; reduced hospitalization 86 percent and cut taxpayer costs 40 percent.<sup>4</sup> Similar results have been achieved in the other states that use it. Research shows 80% of those with serious mental illness who have actually received these types of services say they help them get well and stay well.<sup>5</sup> Laura's Law requires non-profit mental health organizations to accept the most seriously ill into their programs.

### Problems:

Commissioners gave \$9 million in MHA funds to organizations --including their own- that are working to prevent counties from providing Laura's Law services to individuals with serious mental illness who could benefit from them.<sup>6</sup>

### Disability Rights California – Eduardo Vega \$3 million

During the period of our investigation, Disability Rights California received a \$2.9 million in MHA funds (via CalMHA) ostensibly to "address stigma and discrimination by examining laws, policies, and practices". DRC threatens counties that are considering implementing Laura's Law<sup>7</sup>, lobbies in favor of legislation to make Laura's Law difficult to use<sup>8</sup>, and spreads disinformation on Laura's Law<sup>9</sup>. Eduardo Vega was an Oversight Commissioner and board member of Disability Rights California.

### California Network of Mental Health Clients – Sally Zinman/Delphine Brody \$1.5 million

During the period of our investigation, under the guise of "reducing stigma", \$1,539,225 was given to California Network of Mental Health Clients, an organization that worked vigorously to prevent implementation of Laura's Law.<sup>10</sup> Two individuals associated with the Oversight Commission, Sally Zinman and Delphine Brody, were in CNMHC leadership positions.<sup>11</sup> In addition to using the funds to support their work in opposing Laura's Law, funds were diverted by other CNMHC employees to personal use.<sup>12</sup>

### Mental Health America (MHA) Associations – \$3 million (MHA/CA) and \$2.9 million (MHA/SF)

Multiple grants went to MHA/CA and subsidiaries in San Francisco, LA and elsewhere. Rusty Selix (ED, MHA/CA) and Eduardo Vega (MHA/SF) regularly lobby against Laura's Law.<sup>13</sup>

<sup>1</sup> Section 5346(a)(8). Extensive information on Laura's Law is available at <http://lauras-law.org>, a project of Mental Illness Policy Org.

<sup>2</sup> See Anosognosia at <http://mentalillnesspolicy.org/medical/anosognosia-studies.html>

<sup>3</sup> "The Nevada County Experienced", Michael Heggarty, <http://lauras-law.org/states/california/nevada-aot-heggarty-8.pptx.pdf>

<sup>4</sup> County of Los Angeles. "Outpatient Treatment Program Outcomes Report" April 1, 2010 – December 31, 2010. And Michael D.

Antonovich, Los Angeles County Fifth District Supervisor, Los Angeles Daily News, December 12, 2011

<sup>5</sup> <http://lauras-law.org/aot/consumers-like-aot.html>

<sup>6</sup> Most of this money is distributed via CalMHA, which pools county MHA funds for statewide efforts. CalMHA expenditures are

approved by Oversight Commissioners. Read "MHA can Fund Laura's Law" at <http://lauras-law.org/states/california/ok2usemhsa4ll.pdf>

<sup>7</sup> <http://lauras-law.org/states/california/p&aopposition.pdf>

<sup>8</sup> <http://www.sfgate.com/opinion/openforum/article/Laura-s-Law-is-ineffective-3433801.php>

<sup>9</sup> <http://lauras-law.org/states/california/disability-advocates-sacbee.html>

<sup>10</sup> See [http://www.californiaclients.org/policy/policy\\_arguements.cfm](http://www.californiaclients.org/policy/policy_arguements.cfm) Accessed 7/13/12

<sup>11</sup> Ms. Zinman founded and Ms. Brody was Director of Public Policy for the California Network of Mental Health Clients. In addition, Delphine Brody is on the MHSOAC Services Committee and Sally Zinman is on the Client and Family Leadership Committee.

[http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC\\_2011MHSOACCommitteeMembers.pdf](http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf) and <http://www.californiaclients.org/>

<sup>12</sup> <http://www.sacbee.com/2012/11/11/4976722/3-million-in-state-contracts-yanked.html>

<sup>13</sup> [http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw\\_12-26.html](http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html)

# The Failed Stakeholder Process

## Background

MHSA legislation codifies a stakeholder process to provide input to county MHSA plans<sup>14</sup>

**Problems:** In every county we looked into, we found the stakeholder process was fatally flawed and in most counties the process led by the county behavioral health director. The stakeholder groups were primarily composed of representatives and clients of social service and mental 'health' programs that do not serve people with serious mental illness and wanted funding for their own favored programs.

1. Professionals with experience treating and caring for the most seriously mentally ill were not part of the stakeholder process. i.e, police, sheriffs, corrections, district attorneys, inpatient doctors, inpatient nurses, doctors at homeless shelters, and others who treat the seriously ill individuals who are shunned by mental 'health' providers.
2. Stakeholders were allowed to prioritize programs that lacked evidence of efficacy or were known to be ineffective.
3. A billion dollar feeding frenzy erupted as programs tried to get MHSA funds for their own programs.
4. County behavioral health directors blindly accepted stakeholder input, even when inconsistent with the legislation.

## Results:

1. Social Service programs that don't serve seriously mentally ill were prioritized for funding.
2. Programs received funding in spite of lack of evidence they work or known evidence they don't.
3. Programs that serve people with serious mental illness went unfunded.

### **Case Study: Fresno County allowed stakeholder input to trump helping people with serious mental illness:**

The director of behavioral health services in Fresno County said "(H)e would like more of the Mental Health Services Act money to treat people with severe mental illness. With county budgets tight, he said, the priorities should be "crisis first, treatment and then early intervention, prevention. Evans said the county plan isn't perfect, but it is a compromise between what the community wants and what the staff sees as gaps in the system "It's all a compromise," she said.

(Fresno Bee, January 6, 2013)

### **Case Study: Sacramento County allowed stakeholder input to trump helping people with serious mental illness.**

At a Sacramento County Mental Health Board Meeting in May 2013 attendants were told about PEI "Strengthening Families Project". Within this program are Quality Child Care Collaborative, HEARTS for Kids, Bullying Prevention Education and Training, Early Violence Intervention Begins With Education and Independent Living Program 2.0. Someone noted these were social services programs and ineligible for MHSA funding. They were told, "when the public hearing were held on these programs, the community wanted them"

### **Case Study: Butte County allowed stakeholder input to trump helping people with serious mental illness.**

Butte County's failed stakeholder process led to the funding Hmong Gardens. Butte did a study of the need for housing for people of Hmong ancestry. Eight people participated. We do not know if any had serious mental illness or if any housing was ever built. But this 'study' found that two important services for this housing that is not limited to people with mental illness are "gardens" and a "community room". The researchers aggregated the two to conclude that if they built housing, 58% wanted "community room and garden" and therefore a garden was a service that prevents mental illness from becoming severe and disabling and was included in the PEI Plan (See discussion of Butte under county misspending chapter).

<sup>14</sup> WIC 5848 (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans."

## Los Angeles County as Case Study of Failed Stakeholder Process

**LA County stakeholders were primarily those who provide social services to people without serious mental illness** LA conducted an extensive, expensive stakeholder input process that included social service and 'mental health' groups who were vying for MHSAs funding for their social service programs.<sup>15</sup> The stakeholder process included a

- A 100 member "Stakeholder Delegate Group" representing various special interests seeking funding.
- A 29 member Ad hoc "Plan to Plan Advisory Group" that included representatives of those seeking funding;
- A 28 member Ad hoc "Guidelines Advisory Group" largely comprised of those seeking funding;
- A 25 member ad hoc "PEI Plan Development Advisory Group", largely comprised of those seeking funding; and
- A 150 member "Service Area PEI Ad Hoc Steering Committee" many representing programs seeking funding.

**LA County excluded stakeholders with the most expertise in serious mental illness.**

- There was no input from persons with mental illness who are in inpatient units
- There was no input from mentally ill patients who live in jails or prisons. About 30% of LA County prisoners have serious mental illness. LA County Jail is the largest psychiatric facility in the state. There are 3 times as many Californians with mental illness in jails than hospitals.<sup>16</sup>
- We are unaware of any attempts to seek input persons with mental illness who live in shelters or are homeless.

We believe the failure to solicit and prioritize input from the most seriously ill and those who know most about the population the legislation states "deserve priority attention" led to a plan that made eligible individuals ineligible and diverted the funds to other.

**LA County Behavioral Health Department misinterpreted the legislation and failed to reject stakeholder recommendations that were outside the law.**

The Home Page<sup>17</sup> for the Los Angeles County Prevention and Early Intervention (PEI) Plan<sup>18</sup> states

*The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by **some level of mental health issue**" (emphasis added).*

That is incorrect. PEI funding is limited to those with mental "illness" or "serious mental illness" not "some level of mental health issue."<sup>19</sup> This misinformation is repeated in the 2009-2010 Plan.<sup>20</sup> This is not just nomenclature; there is a significant difference between those "who may be affected by some level of mental health issue" (i.e., can be made happier), and

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<sup>15</sup> To develop their Community Support Service (CSS) plan, LA County conducted a needs and strengths assessment with over 2000 people, conducted workgroup, and community engagement meetings involving over 11,000 participants, and conducted 17 meetings with an average participation of over 200 people; in addition to the public hearing on September 20, 2005 which drew over 400 people. While community input is to be commended, the result of that input can not be allowed to supersede the law. (See 9/25/05 letter and attachments from Marvin Southard, LA County MH Director to Board of Supervisors) which set the framework for all future CSS spending. Available at

[http://lacdmh.lacounty.gov/News/Board\\_Correspondence/Adopted\\_Board\\_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSAs%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH\\_101105.pdf](http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSAs%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH_101105.pdf) .

<sup>16</sup> The doctors, social workers, parole and correction officials who work there are much more informed as to what persons with serious mental illness need, but in spite of that, were not consulted and prioritized.

<sup>17</sup> [http://dmh.lacounty.gov/wps/portal/dmh/lut/p/b1/vZLdjoIwEIWfhQfYzJTys16ibUFjQaAu0huDycYoKJv9Y-Xpt9wZE\\_Fms52rzjmd801S0FASJNS3PUo82IA-V9-HffV5aM9VM9y1t-WIGCYit0MqApXzRIW8csha2cZQXuJJSJnRneVsKhzTpDD-uoByOowwLrxzAnyEUIAeiUHp3ug3kCGO68MSMA4YR-3pFUoD6t\\_DmEQeKNigs82PI7d5X\\_fZsU9\\_Pt6DTu14JxmnMYSXOX4RydYk78VK1W4Sq0wq3vVETsiLShkg7IllqfUozP\\_PMPdPwxag9027M5-vmMFJN8vLU51FHxkeqgss6xfMabNu/dl4/d5/L2dJQSEvUU3QS80SmtFL1o2X0UwMDBHT0ZTMkczRkEwSUVEM1ROUDQxOTY0/](http://dmh.lacounty.gov/wps/portal/dmh/lut/p/b1/vZLdjoIwEIWfhQfYzJTys16ibUFjQaAu0huDycYoKJv9Y-Xpt9wZE_Fms52rzjmd801S0FASJNS3PUo82IA-V9-HffV5aM9VM9y1t-WIGCYit0MqApXzRIW8csha2cZQXuJJSJnRneVsKhzTpDD-uoByOowwLrxzAnyEUIAeiUHp3ug3kCGO68MSMA4YR-3pFUoD6t_DmEQeKNigs82PI7d5X_fZsU9_Pt6DTu14JxmnMYSXOX4RydYk78VK1W4Sq0wq3vVETsiLShkg7IllqfUozP_PMPdPwxag9027M5-vmMFJN8vLU51FHxkeqgss6xfMabNu/dl4/d5/L2dJQSEvUU3QS80SmtFL1o2X0UwMDBHT0ZTMkczRkEwSUVEM1ROUDQxOTY0/)

<sup>18</sup> Described starting on Page 6 of Prevention and Early Intervention Plan for Los Angeles County, 8/17/2009. Available at [http://lacdmh.lacounty.gov/News/Board\\_Correspondence/Adopted\\_Board\\_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSAs%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH\\_101105.pdf](http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSAs%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH_101105.pdf)

<sup>19</sup> WIC 5840.

<sup>20</sup> "PEI focuses on evidence-based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families." [http://file.lacounty.gov/dmh/cms1\\_159376.pdf](http://file.lacounty.gov/dmh/cms1_159376.pdf)

those who have serious mental illnesses like schizophrenia and treatment resistant bipolar disorder. The funds are legislatively required to help the later, not the former.<sup>21</sup>

### **LA County Mental Health Department Plan relied on guidance from the California Department of Mental Health and MHSOAC that was contrary to statute, rather than relying on the statute itself<sup>22</sup>**

LA County justifies the part of their plan that uses funds to ‘encourage a state of well being’ and target a population group ‘not identified on the basis of risk’, by quoting direction from the Oversight Commission:

*Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. **Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. Universal Prevention targets the general public or a whole population group that has not been identified on the basis of individual risks.***

MHSA is to help people with serious mental illness, not improve ‘well being’ or ‘target the general population’.

The LA County Plan justifies withdrawing services from people with serious mental illness by quoting direction from the Oversight Commission stating:

*Early Intervention is directed toward individuals and families for whom a **short duration** (usually less than one year), relatively **low-intensity intervention** is appropriate to measurably improve a **mental health problem** or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.<sup>23</sup>*

The LA plan, seems to suggest that PEI funds must be withdrawn once a person is identified. This direction from the former California Dept. of Mental Health and Oversight Commission is not true. To prevent “mental illness from becoming severe and disabling” often requires on-going treatment. By limiting PEI funding to short term, low intensity programs, they have essentially excluded those who face lifelong disability.

### **LA County Behavioral Health Department fails to report data by diagnosis or require a diagnosis so it can not know if it’s programs are serving people “with mental illness” or “serious mental illness” as required by law.**

In order to know if a program is targeting those with mental illness or preventing mental illness from becoming severe and disabling, officials would have to collect data on the

- 1 diagnosis of people being served,
2. diagnosis of the mental illness the program is ‘preventing’
3. Diagnosis of the mental illness that they reduced duration of

This information is not collected or provided by the county.

### **Los Angeles’ failed stakeholder process led to a failed spending plan.**

The failed stakeholder process led to failed spending. For example, while serious mental illnesses are most likely to strike in late teens early twenties, LA allocated 60% of funds to Transition Age Youth.<sup>24</sup> Less than 3% of individuals in LA County PEI were the most seriously ill individuals with psychotic disorders.<sup>25</sup> Rather than focusing on the most seriously

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<sup>21</sup> This distinction is very clear from the first “Findings and Declarations”. The legislation notes that “Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age.” But then the legislation goes on to talk about “serious” mental illness: “In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.”. The “Intent” of the legislation is then clearly defined: “To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services...” (emphasis added)

<sup>22</sup> On page two of the LA County PEI Plan they note that “On September 25, 2007 SDMH (State Dept. of Mental Health) released the Prevention and Early Intervention Guidelines” Many of these guidelines and regulations were contrary to the legislation and had the effect of (a) preventing those the funds were intended to serve from gaining access and (b) diverting those funds to organizations that used them to provide services to ineligible populations.

<sup>23</sup> Page five at [http://file.lacounty.gov/dmh/cms1\\_179197.pdf](http://file.lacounty.gov/dmh/cms1_179197.pdf)

<sup>24</sup> [http://file.lacounty.gov/dmh/cms1\\_179197.pdf](http://file.lacounty.gov/dmh/cms1_179197.pdf)

<sup>25</sup> Page 101 Table 4 County Plan at [http://file.lacounty.gov/dmh/cms1\\_179197.pdf](http://file.lacounty.gov/dmh/cms1_179197.pdf)

ill, LA focus is “clients at higher levels of recovery.”<sup>26</sup> We could not find a single program that was designed specifically to help people with psychotic disorders or help the homeless who are at risk of becoming psychotic because they can’t get medicine.

Incarceration of children went up.<sup>27</sup> This is surprising because one of the programs, “Incredible Youth” (\$200K) is supposed to decrease incarceration.

\$2,393,926 of funding for “at risk” families is likely wasted.<sup>28</sup> They are social service programs that purport to help people ‘at risk’ of mental illness. There are no known factors that put people at risk of “serious” mental illness (other than having a parent with it, which is a genetic issue). There are issues, like losing a family member or job that do put people at risk of being sad, being depressed, but not of the most serious mental illnesses like schizophrenia and bipolar disorder that MHSA was intended to prioritize.

\$2,899,231 of Trauma Recovery spending are likely wasted<sup>29</sup>. Trauma is not a mental illness. Almost everyone experiences trauma of some degree of severity (losing a loved one, having an accident, witnessing something horrible). PTSD is a mental illness. Severe traumatic events (being held prisoner, war, etc.) might cause trauma disorder. But these services are likely going to people who experienced the rights of passage we all experience: knowing someone who died, failing a grade in school, breaking up with a boy/girlfriend, not paying rent, etc. For example, “Incredible Years” is a crime prevention initiative aimed at aggressive youth.

Many of the other programs Los Angeles is spending on are social service programs masquerading as mental illness programs: Reflective Parenting, Strengthening Families, Positive Parenting, Brief Strategic Family Therapy, Loving Intervention for Family Enrichment Program, Multidimensional Family Therapy Program and Promoting Alternative Thinking Strategies.

## **CONCLUSION**

Flawed process led to massive mission creep. A stakeholder driven “gold rush” that excluded experts who work with the seriously mentally ill resulted in funding programs not directly related to the purpose of PEI or MHSA.

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<sup>26</sup> Page 30. Also see page 88 for stats on how well this group “who are at higher levels of recovery” are doing.

<sup>27</sup> Page 80. Authorities blamed a “coding error”.

<sup>28</sup> Page 120 column six of LA County Plan available at [http://file.lacounty.gov/dmh/cms1\\_179197.pdf](http://file.lacounty.gov/dmh/cms1_179197.pdf)

<sup>29</sup> Page 120 column seven of LA County Plan available at [http://file.lacounty.gov/dmh/cms1\\_179197.pdf](http://file.lacounty.gov/dmh/cms1_179197.pdf)

## Appendix A: Prevention and Early Intervention (PEI) Funds must serve seriously ill

### Legislative Language

(a) The State Department of Mental Health shall establish a program designed to **prevent mental illnesses from becoming severe and disabling**. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of **potentially severe and disabling mental illnesses**.

(2) Access and linkage to medically necessary care provided by county mental health programs for children **with severe mental illness**, as defined in Section 5600.3, and for adults and seniors **with severe mental illness**, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed **with** a mental illness or seeking mental health services.

(4) Reduction in discrimination against people **with mental illness**.

*Discussion: The purpose is "to prevent mental illness from becoming severe and disabling". It is not "to prevent mental illness" (which we don't know how to do) or "improve mental health". Outreach may only be to "recognize the early signs of potentially severe and disabling mental illnesses" not to recognize the signs of poor mental health, bad grades, potential unemployment. The outreach must be narrowly targeted. The responsibility to provide "access and linkage" is only to provide access and linkage "to medically necessary care" and even then, it is only for people who are already "with severe mental illness". It does not prioritize "access and linkage" to non-medical care, or to people without "severe mental illness". Stigma activities are limited to those that affect 'being diagnosed with mental illness' or seeking services. The bulk of misdirected PEI funds are being driven through the 'stigma' requirement. CalMHSA, MHSAC, county behavioral directors justify massive spending that does not focus on 'serious mental illness' by saying it 'reduces stigma' or discrimination. Most of that spending is unjustified and little of it is being done 'cost-effectively'*

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from **becoming severe**, and shall also include components similar to programs that have been successful in reducing the duration of untreated **severe mental illnesses** and assisting people in quickly regaining productive lives.

*Discussion: This does allow funds to be used for people with "mental illness" (20% of population) versus 5-9% who have "serious mental illness". However, the funds may only be expended to prevent that mental illness "from becoming severe". It also allows funding to reduce the duration of "untreated severe mental illness" (i.e., provide treatment). MHSAC, county behavioral health directors, CalMHSA, MHA and others have read the last phrase "assisting people in quickly regaining productive lives" as freeing them from the responsibility to spend the money only on those with 'severe mental illness'*

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from **untreated** mental illness: (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes.

*Discussion: This paragraph allows funding to reduce 1-7 **only insofar as they result from "untreated mental illness"**. Both conditions must be met: 1. Untreated mental illness and 2. One of the seven outcomes. MHSAC, CA DMH, county behavioral health directors, MHA, NAMI, and others have used this provision to provide services that reduce the seven bullet points to people **without** mental illness.*

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the **most effective** prevention and intervention programs for children, adults, and seniors.

*Discussion: Many of the "most effective programs" for people with serious mental illness are not receiving funding. The best known would be Assisted Outpatient Treatment (Laura's Law). The Department of Justice and all research shows it reaches those with "serious mental illness" and reduces arrest, incarceration, homelessness, suicide, suffering and other outcomes.*

## Appendix B: Proposed and/or enacted regulations and guidelines being relied on by counties that diverted funds to people without serious mental illness and left people with serious mental illness without services<sup>1</sup>

Proposed and enacted CCR Title 9 Regulations that diverted funds from seriously mentally ill	How the regulation diverts funds
<p>3400(b) Programs and/or services provided with MHSA funds shall:                      (1) Offer mental health services and/or supports to individuals/clients with serious mental illness and/or serious emotional disturbance, and when appropriate their families.                      (A) <b>The Prevention and Early Intervention component is exempt from this requirement.</b>                      ...                      (d) The County is not obligated to use MHSA funding to fund court mandates.</p>	<p>This exempted Prevention and Early Intervention (PEI) programs from having a tie to serious mental illness.</p> <p>Nothing in MHSA precludes the use of MHSA funds for Laura's Law recipients, yet 3400(d) suggests they don't have to.</p>
<p>3610 (f) The County shall not provide MHSA funded services to individuals incarcerated in state/federal prisons or for parolees from state/federal prisons.</p>	<p>The legislation precludes support for those paroled from state prisons. This reg goes further and prevents funds from helping parolees from federal prisons.</p>

### The following regulations diverted PEI funds away from the intended purpose of the funds.<sup>2</sup>

<p>Section 3930. (d) PEI funds <b>may not be used</b> for the following:                      (1) Individualized treatment, recovery, and support services for those who have been diagnosed with a serious mental illness or serious emotional disturbance, unless the client or individual has been identified by a provider as experiencing first onset of serious mental illness/emotional disturbance.</p>	<p>This reg specifically prevents funds from reaching those "who have been diagnosed with a serious mental illness". Yet the PEI legislation requires funds to be used to "prevent mental illness from becoming severe and disabling". The effect of this legislation is to prevent people with mental illness from receiving services.</p>
<p>Section 3905. (a) The following are Priority Populations for Prevention and Early Intervention programs:                      (1) Racial/ethnic populations and other unserved/underserved cultural populations, including lesbian/gay/bisexual/transgender populations.                      (2) Individuals experiencing onset of a serious mental illness or severe emotional disturbance, as defined in the Diagnostic and Statistical Manual of Mental Disorders.                      (3) Children and youth and transition age youth in stressed families such as families affected by unemployment, homelessness, substance abuse, violence, depression or other mental illness, absence of care-giving adults, or out-of-home placement.                      (4) Individuals exposed to traumatic events or prolonged traumatic conditions, including but not limited to grief, loss, and isolation.                      (5) Children and youth and transition age youth at risk of school failure.                      (6) Children and youth and transition age youth at risk of or experiencing involvement in the juvenile justice system.                      (7) Individuals experiencing co-occurring substance abuse issues.</p>	<p>This regulation severed funding from a requirement to help people with serious mental illness by creating new 'priority populations' who were not required to have a mental illness or be at risk (ex. the first degree relative of someone with mental illness).</p> <p>It diverted funds to employment programs, substance abuse programs, grief programs, tutoring programs, crime prevention programs and substance abuse programs for people without mental illness. It prioritized the youngest while serious mental illness does not materialize until late teens and early twenties.</p>
<p>Section 3200.251. "Prevention and Early Intervention" means ... (1) <i>prevent serious mental illness/emotional disturbance by promoting mental health, reducing mental health risk factors and/or building the resilience of individuals, and/or</i>                      (2) <i>intervene to address a mental health problem early in its emergence.</i></p>	<p>The first part of this reg misstates the purpose of the legislation to "prevent serious mental illness" (No one knows how) "promoting mental health" (make people happier) and "reducing mental health risk factors" (versus serious mental illness) and "building the resilience of individuals".</p> <p>Paragraph (2) limits funds to 'mental health problems early in emergence versus people with serious mental illness whenever they need help. For example, one of the best ways to prevent mental illness from becoming severe and disabling is to ensure treatment. That may be needed early <b>or late</b> in the emergence of the illness.</p>

<sup>1</sup> <http://www.oal.ca.gov/CCR.htm> click on CCR, click online on next page, click on List of CCR titles on next page, click on Title 9. CA Office of Admin Law says that is how to get them and they are official. Accessed 8/27/2012. Some of the regulations discussed here were promulgated, some merely given as direction, some promulgated and allowed to lapse. However, all are being relied on by counties when determining spending priorities.

<sup>2</sup> They are still on MHSAOC and CADMH websites and counties are still relying on them, although some seem to have expired, lapsed or never been promulgated.

<p>Section 3920 (b) Prevention programs shall be designed to reduce risk factors or stressors and build protective factors and skills <b>prior to the diagnosis</b> of a mental illness and shall include one or both of the following:</p> <p>Section 3200.259. "Selective Prevention Activity" means a prevention activity within a PEI program that targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average, such as older adults who have lost a spouse or young children whose mothers have postpartum depression.</p> <p>Section 3200.305. "Universal Prevention Activity" means a prevention activity within a PEI program that targets the general public, or a population group that has not been identified on the basis of individual risk, such as an activity that educates school-aged children and youth on mental illnesses.</p>	<p>3920(b) <i>requires</i> the expenditure of MHSA funds on people "prior" to diagnosis. There is no language that suggests PEI funds were meant for those without any mental illness at all. It also suggest that there are known 'protective factors' and 'skills' that can prevent serious mental illnesses like schizophrenia and bipolar. We are not aware of any. Using MHSA funds to lower risk factors in populations without mental illness is perhaps one of the most inefficient, less productive, most wasteful uses of MHSA funds. The primary risk factor of developing serious mental illness is being born to someone with serious mental illness.</p> <p>"Selective Prevention Activity" allows expenditure for people <i>at risk of developing any mental illness</i>, rather than limiting it to those with "serious mental illness" or to preventing mental illness from progressing to 'serious mental illness". We are not aware of research that schizophrenia or bipolar rates are increased by normal rights of passage like losing a spouse. (Although they can exacerbate symptoms in those already diagnosed). High risk should be those with one or two parents with serious mental illness. They are not mentioned in the reg.</p> <p>"Universal Prevention" diverts funds to the public who have "not been identified on the basis of individual risk". The program was meant to help people at risk, not those who have "not" been identified as being at risk. It basically diverts funds to PR firms.<sup>3</sup></p>
<p>Section 3920. (c) Early Intervention programs shall target individuals exhibiting signs of a potential mental health problem, and/or their families, to address the individual's mental health problem early in its emergence.</p> <p>(1) Services shall not exceed one year, unless the individual receiving the service is identified as experiencing first onset of serious mental illness with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders criteria for a psychotic disorder, in which case, an intervention shall not exceed five years.</p> <p>(g) PEI programs shall serve individuals and populations in non-traditional mental health settings such as primary healthcare clinics, schools, and family resource centers; unless a traditional mental health setting enhances access to quality services and outcomes for unserved/underserved populations.</p>	<p>3920(c) diverts funds away from "serious mental illness" or even "mental illness" to people exhibiting signs of a <i>potential</i> mental <i>health</i> problem." In fact, it diverts funds even further away to cover "their families".</p> <p>3920(c)(1) requires stopping services for individuals experiencing onset of serious mental illness after one year if they are not psychotic and after five years if they are. The services needed to prevent mental illness from becoming severe and disabling may be long-term life long services. This reg prohibits that expenditure contrary to the legislation.</p> <p>3920(g) pushes for services to be outside where mentally ill people are: i.e. mental health settings.</p>
<p>Section 3950. (a) The County shall participate in the Department's accountability, evaluation and improvement activities for the Prevention and Early Intervention (PEI) component as follows:</p> <p>(1) Submit the PEI Program Accountability and Evaluation Report as required in section 3570 and the Local Outcome Evaluation of a PEI Program Report as required in section 3515, unless exempt per section 3515, subdivision (g).</p> <p>(2) Participate in on-site reviews conducted by Department.</p> <p>(3) Complete surveys conducted by the Department.</p>	<p>3950 requires "evaluation" by MHAOC. That is a good thing. But minutes from the oversight committee show the Oversight Commission evaluates "based on what counties said they were going to do, rather than actual on-the-ground assessment."<sup>4</sup></p>

<sup>3</sup> Universal Prevention Activity is the most egregious blatant attempt to divert PEI funds to unintended uses. It diverts funds from helping individuals to creating brochures, radio programs, and other activities aimed at the public. People who are "not identified on the basis of individual risk". MHSAOC defines it on their web site as "*one of the categories of prevention funded by the California Mental Health Services Act (MHSA). Universal prevention programs target the whole population or a subset of the population that does not have a higher risk for developing the symptoms of mental illness*" There is nothing in Prop 63, that suggests the funds were meant other than for people with mental illness.

<http://www.preventionearlyintervention.org/go/PromotingWellnessPrevention/UniversalPrevention.aspx>

<sup>4</sup> Oversight Commission Minutes [http://mhsoac.ca.gov/Meetings/docs/PriorMeetingMinutes/2011/MinutesApproved\\_Sept2011.pdf](http://mhsoac.ca.gov/Meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf)

## Appendix C: How AB-100 that diverted \$863 million from intended recipients and provisions in AB-1467 exempted \$50 million annually from helping persons with serious mental illness.

The content that diverted funds in both these bills was proposed by the Senate Leader Pro Tem Darrell Steinberg<sup>1</sup>.

### AB 100<sup>2</sup>

California had preexisting responsibilities to serve people with serious mental illness, some of which were mandated by courts. For example, to special education students. When passing Proposition 63, voters included a provision stating the funds shall not be used to supplant other state funding<sup>3</sup>. In other words, the funds should be used to increase capacity not fund already funded initiatives. In 2011, legislators passed AB 100 with provisions inserted by Senator Steinberg. It modified the MHSA non-supplantation provision to allow the state to divert about \$836 million of funds raised by MHSA to satisfy the other commitments the state had. This was done as a 'clarifying' amendment to allow passage with a 51% vote rather than a two-thirds vote required to overturn voter enacted legislation.

This amendment used MHSA funds to be used to lower the deficit, rather than expand services.

### AB 1467<sup>4</sup>

When Proposition 63 was originally passed, voters allocated 5% of MHSA funds for Innovative Services

"To expand the kinds of successful, innovative service programs for children, adults and seniors... (that) have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, **to individuals most severely affected by or at risk of serious mental illness.**" The programs would be approved by the Oversight Commission and were "(1) To increase access to underserved groups. (2) To increase the quality of services, including better outcomes. (3) To promote interagency collaboration. (4) To increase access to services."<sup>5</sup>

In July 2012, AB1467 added new language that greatly expanded the allowable uses of these funds. The legislation severed the tie of Innovative Funds from helping "**individuals most severely affected by or at risk of serious mental illness**" to doing almost anything for anyone. In part, new language stated

"An innovative project may affect **virtually any aspect of mental health practices** or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:  
(1) Administrative, governance, and organizational practices, processes, or procedures. (2) Advocacy. (3) Education and training for service providers, including nontraditional mental health practitioners. (4) Outreach, capacity building, and community development. (5) System development. (6) Public education efforts. (7) Research. (8) Services and interventions, including prevention, early intervention, and treatment.

It freed funds for advertising, yoga, advocacy, community development, almost anything.

This amendment was passed with a simple majority, rather than the 2/3rds vote that should have been required. This was accomplished by defining it as a 'clarifying' amendment rather than what it really was: an amendment that changed a voter initiative.

This amendment diverted funds from people with serious mental illness.

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<sup>1</sup> They have 'AB' numbers because the Pro Tem's language was attached to bills already in process.

<sup>2</sup> [http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab\\_0051-0100/ab\\_100\\_cfa\\_20110315\\_103004\\_sen\\_floor.html](http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0051-0100/ab_100_cfa_20110315_103004_sen_floor.html)

<sup>3</sup> There is a "non-supplantation" clause of Prop 63 that requires the maintenance of funding for previously existing programs so MHSA funds can result in incremental activity. "5891. The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year..."

<sup>4</sup> [http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab\\_1451-1500/ab\\_1467\\_cfa\\_20120613\\_164453\\_sen\\_comm.html](http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1451-1500/ab_1467_cfa_20120613_164453_sen_comm.html)

<sup>5</sup> WIC 5830

## Appendix D: Personal and Professional Contacts for Media

Contact DJ Jaffe at Mental Illness Policy Org for a copy of Appendix D

<http://mentalillnesspolicy.org>

<http://lauras-law.org>

<http://kendras-law.org>

**MENTAL ILLNESS POLICY ORG.**  
UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA  
50 EAST 129 ST., PH7 NEW YORK, NY 10035  
OFFICE@MENTALILLNESSPOLICY.ORG

X INFORMATION

TAB SECTION: E

\_\_\_ ACTION REQUIRED: None

DATE OF MEETING: 10/16/13

PREPARED BY: Adcock

DATE MATERIAL

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AGENDA ITEM: CMHPC Mandates Work Plan

ENCLOSURES: • CMHPC Mandates Work Plan

OTHER MATERIAL RELATED TO ITEM:

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