



May 19, 2016

To: California Mental Health Planning Council

From: Jane Adcock  
Executive Officer

Subject: June 2016 Planning Council Meeting

CHAIRPERSON  
Josephine Black

EXECUTIVE OFFICER  
Jane Adcock

Enclosed is the packet for the June 15-17, 2016 Planning Council meeting at the Holiday Inn Golden Gateway in San Francisco, CA. The hotel is located at 700 North Haven Avenue, Ontario, CA 91764. The hotel offers complimentary guest and meeting room internet.

### **Issue Request Form**

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

➤ **Advocacy**

➤ **Evaluation**

➤ **Inclusion**

### **Mentorship Forum**

A Mentorship Forum will be held the evening of **Thursday, June 16**, immediately following the general session. Planning Council officers and all committee chairs and vice-chairs are specifically requested to attend. Other Planning Council members who wish to benefit from the discussion are welcome to attend.

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

### **Committee Reports**

We have allocated 35 minutes for committee reports on Friday. The focus of the committee reports will be what tasks or objectives the committee has completed on its projects and on its work plan. In addition, the committee should report any action items that it has adopted.

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

Enclosures

MS 2706  
PO Box 997413  
Sacramento, CA 95899-7413  
916.323.4501  
fax 916.319.8030

**AGENDA**  
**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**  
**June 15, 16, 17, 2016**  
**Ontario Airport Hotel**  
**700 N Haven**  
**Ontario, CA 91674**

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

**Wednesday, June 15, 2016**

**COMMITTEE MEETINGS**

<b>Time</b>	<b>Event</b>	<b>Room</b>
8:30 a.m.	Executive Committee Meeting	Sage Room
11:00 a.m.	Patients' Rights Committee Meeting	Sage Room

**PLANNING COUNCIL GENERAL SESSION**

**Ponderosa Ballroom**

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

**Participant Code: 8936702**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
1:30 p.m.	Welcome and Introductions	Josephine Black, Chairperson	
1:40 p.m.	Opening Remarks	CaSonya Thomas, MPA, CHC, Director, and Michael Schertell, Deputy Director, San Bernardino County Dept. of Behavioral Health	
2:00 p.m.	Overview of San Bernardino County Substance Use Services and Programs	Veronica Kelly, LCSW, Assistant Director, San Bernardino County Dept. of Behavioral Health	Q
2:35 p.m.	Council Questions and Discussion	All	
2:50 p.m.	Public Comment	Jo Black, Chairperson	
3:00 p.m.	<b>Break</b>		
3:15 p.m.	Approval of Minutes from April 2016 meeting	Jo Black, Chairperson	R
3:20 p.m.	Approval of 2016 Policy Platform	Darlene Prettyman, Advocacy Committee Chair	S

**California Mental Health Planning Council**

3:35 p.m.	Recovery Lifestyles Program, a SUD Treatment Program at Patton State Hospital	Troy Freimuth, PsyD, Patton State Hospital	T
4:20 p.m.	Council Questions and Discussion	Jo Black, Chairperson	
4:50 p.m.	Public Comment	Jo Black, Chairperson	
5:00 p.m.	<b>Recess</b>		

**Thursday, June 16, 2016**

**COMMITTEE MEETINGS**

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

**PLANNING COUNCIL GENERAL SESSION**

**Ponderosa Ballroom**

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

**Participant Code: 8936702**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
1:30 p.m.	Welcome and Introductions	Josephine Black, Chairperson	
1:40 p.m.	Overview of California's Child Welfare Continuum of Care Reform	Cheryl Treadwell, Chief Foster Care Rates and Audits Branch, CDSS	U
1:55 p.m.	Panel re: Mental Health Services to Children in Foster Care including under the Katie A. Court Order	Court Appointed Special Advocate, Foster Care Ombudsman and former/current Foster Parents, San Bernardino and Riverside Counties	V
2:40 p.m.	Council Questions and Discussion	All	
2:55 p.m.	Public Comment	Jo Black, Chairperson	
3:00 p.m.	<b>Break</b>		
3:15 p.m.	Panel regarding Outcomes and Support for Youth Exiting Foster Care Including Support Under AB 12	AB 12 Coordinator, AB 12 Service Provider(s) and Youth with Lived Experience of San Berdo County	W

**California Mental Health Planning Council**

4:00 p.m.	Council Questions and Discussion	All	
4:15 p.m.	Report from Dept. of Health Care Services	Karen Baylor, PhD., Deputy Director, Mental Health and Substance Use Disorders Services	
4:40 p.m.	Public Comment	Jo Black, Chairperson	
4:50 p.m.	Council Debrief	All	
5:00 p.m.	<b>Recess</b>		

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

**Friday, June 17, 2016**

**PLANNING COUNCIL GENERAL SESSION**

**Ponderosa Ballroom**

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

**Participant Code: 8936702**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
8:30 a.m.	Welcome and Introductions	Josephine Black, Chairperson	
8:40 a.m.	Opening Remarks	Monica Wilson, PhD, Chairperson, San Bernardino County Behavioral Health Commission	
9:00 a.m.	Report from the California Assoc of Local Behavioral Health Boards/Commissions	Larry Gasco, Ph.D., LCSW, President	
9:15 a.m.	Report from CA Behavioral Health Directors Association	Noel O'Neill, Director, Trinity County	
9:30 a.m.	Report from Mental Health Services Oversight and Accountability Commission re: Children's Crisis Report	Sheridan Merritt, Research Program Specialist, MHS Oversight and Accountability Commission	
9:50 a.m.	Executive Officer's Report	Jane Adcock, Executive Ofcr	
10:00 a.m.	<b>BREAK</b>		
10:15 a.m.	Committee Reports – Patients' Rights, Health Care Integration, Continuous System Improvement and Advocacy	Daphne Shaw, Chair PRC Terri Lewis, Chair HCI, Lorraine Flores, Chair CSI and Darlene Prettyman, Chair Advocacy	

**California Mental Health Planning Council**

10:50 a.m.	Public Comment	Jo Black, Chairperson	
11:00 a.m.	Planning Council Behavioral Health Integration Strategic Plan Framework Discussion	Bruce Emery and BH Steering Committee Members	W
11:55 a.m.	Closing	Jo Black, Chairperson	
12:00 p.m.	<b>ADJOURN</b>		

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

If Reasonable Accommodation is required, please contact Chamenique Williams at 916.552.9560 by June 3, 2016 in order to make arrangements to meet the request.

**2016 MEETING SCHEDULE**

October 2016	October 19, 20, 21	Sacramento	Lake Natoma Inn 702 Gold Lake Drive Folsom, CA 95630
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**2017 MEETING SCHEDULE**

January 2017	January 18, 19, 20	San Diego	To Be Determined
April 2017	April 19, 20, 21	Oakland	To Be Determined
June 2017	June 14, 15, 16	Orange	To Be Determined
October 2017	October 18, 19, 20	Sacramento	To Be Determined

California Mental Health Planning Council

Executive Committee

Wednesday, June 15, 2016

Ontario Airport Hotel  
700 N. Haven Avenue  
Ontario, CA 91764

**Sage Room**  
**8:30 to 10:30 a.m.**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
8:30	Welcome and Introductions	Josephine Black, Chairperson	
8:35	April 2016 Executive Committee Minutes	Jo Black, Chairperson	1
8:40	FY 2015-16 Council Budget and Expenditures and Update on Contract Solicitations	Tamara Jones, Chief of Operations	2
8:55	Review and Approval of 2016-17 Transparency Statement	Jane Adcock, Executive Officer	3
9:05	Discussion of Council Focus on Children/Youth and Planning for 2016-17 General Session Presentations	All	4
9:35	Discussion of Public Forums and Planning for 2016-17	All	5
9:50	Update on Integration of SUD and Report on Little Hoover Commission Hearing re: MHSA	Jane Adcock, Daphne Shaw	
10:05	Liaison Reports for CALMHB/C and CCMH	Susan Wilson and Daphne Shaw	
10:20	Public Comment	Jo Black, Chairperson	
10:25	New Business	Jo Black, Chairperson	
10:30	Adjourn		

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

California Mental Health Planning Council

**Patients' Rights Committee**

**June 15, 2016**

**Ontario Airport Hotel-Sage Room**

**700 North Haven Avenue Ontario, CA 91764**

**11:00 a.m. to 12:30 p.m.**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
11:00 a.m.	Welcome and Introductions	Daphne Shaw, Chair	
11:05	Agenda Review	Daphne Shaw, Chair	
11:10	Review and approve April 2016 meeting minutes	Daphne Shaw, Chair	A
11:15	Discuss Issue of Ratio of Patients' Rights Advocates and review of enclosures. Report out from 5/18 CAMHPRA meeting	Jim Preis Executive Director Mental Health Advocacy Services, Inc.	B
12:00	Discuss/Review Projects on Work Plan	All	C
12:15	Plan for Next Meeting/Report Out	All	
12:25	Public Comment		
12:30	Adjourn		

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

**Committee Members:**

**Co-Chairs:**        **Daphne Shaw**                      **Cindy Clafin**

**Members:**        Adam Nelson, MD                      Dan Brzovic  
                          Carmen Lee                              Richard Krzyzanowski  
                          Walter Shwe

**Staff:**                Tom Orrock                              Jane Adcock, EO

**If reasonable accommodations are required, please contact the CMHPC office at (916) 323-4501 not less than 5 working days prior to the meeting date.**

California Mental Health Planning Council

**Executive Committee Members:**

<b>Officer Team</b>	Jo Black	Susan Wilson	Cindy Claflin
<b>Advocacy Cmte</b>	Darlene Prettyman	Maya Petties	
<b>CSI Cmte</b>	Lorraine Flores	Walter Shwe	
<b>HCI Cmte</b>	Terri Lewis	Robert Blackford	
<b>Patients' Rights</b>	Daphne Shaw	Cindy Claflin	
<b>Liaisons</b>	Daphne Shaw, CCMH	Susan Wilson, CALBHB/C	Noel O'Neill, CBHDA
<b>At Large</b>	Arden Tucker, Consumer		
<b>Executive Officer</b>	Jane Adcock		

**If reasonable accommodations are needed, please contact Chamenique at (916) 552-9560 not less than 5 working days prior to the meeting date.**

California Mental Health Planning Council

**Advocacy Committee  
Thursday, June 16, 2016**

Ontario Airport Hotel  
700 North Haven Avenue  
Ontario, Ca 91764

**Yosemite Room 1  
8:30 a.m. to 12:00 noon**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
8:30 am	Welcome and Introductions	Darlene Prettyman, Chairperson	
8:35	Agenda Review	Darlene Prettyman	
8:40	Approval of Minutes from April and May 2016	Darlene Prettyman and All	A
8:40	Work Plan	Darlene Prettyman and All	B
9:35	Break		
9:50	Legislative and Regulatory Updates related to Mental Health may be discussed, including but not limited to: Consent Calendar, Legislation Active List	Darlene Prettyman and All	C
10:50	Committee Process Discussion	Darlene Prettyman and All	
11:35	Public Comment	Darlene Prettyman and All	
12:00 pm	Adjourn	Darlene Prettyman	

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

**Committee Officers:**

**Chairperson:** Darlene Prettyman

**Chair Elect:** Maya Petties

**Members:** Barbara Mitchell, Daphne Shaw, Monica Wilson, Arden Tucker, Steve Leoni, Adam Nelson, Carmen Lee, Amy Eargle

**Staff:** Dorinda Wiseman

**If reasonable accommodations are required, please contact Chamenique Williams at (916) 323-4501 not less than 5 working days prior to the meeting date.**

**California Mental Health Planning Council**  
**Continuous System Improvement Committee**  
**Ontario Airport Hotel - Carson Room**  
**700 North Haven Avenue Ontario, CA 91764**  
**June 16, 2016**  
**8:30am – 12:00pm**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
8:30am	Planning Council issue requests	All members	
8:35am	Welcome and Introductions	Lorraine Flores, Chair Walter Shwe, Chair-elect	
8:40am	Review/approve April minutes	All members	A
8:50am	Data Notebook 2016: Planning, design, and update on draft questions.	Susan Wilson, Linda Dickerson	B
10:30am	Discussion regarding LGBTQ action items	Lorraine Flores, Chair	C
11:45am	Evaluate meeting/Develop agenda for next meeting	All members	
11:55am	Public comment		

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

Committee Members:

**Chair: Lorraine Flores**

**Chair-Elect: Walter Shwe**

Members:

Karen Hart, Celeste Hunter, Esmeralda Liberato,

Raja Mitry, Monica Nepomuceno, Noel O'Neill, Susan Wilson

**If reasonable accommodations are needed, please contact the CMHPC at (916) 323-4501 no less than 5 working days of the meeting date.**

California Mental Health Planning Council

Healthcare Integration Committee

Thursday, June 16, 2016

Ontario Airport Hotel

700 North Haven Avenue Ontario, CA 91764

ROOM: Cypress Room

8:30 a.m. to 12:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Terry Lewis, Chairperson	
8:40 a.m.	Review and Approve Meeting Highlights	All	A
8:45 a.m.	Brief Recap of April Meeting	Terry Lewis, Chairperson	
9:00 a.m.	Background/History of the HCI Committee and Charter Review	Terry Lewis, Chairperson Robert Blackford, Chair-Elect	
9:30 a.m.	Work Plan Review	Robert Blackford, Chair-Elect	B
10:15 a.m.	Discussion : Work Plan Goal #2 (Explore the health effects of psychotropic Medications on Children and alternatives to medication)	All	
10:45 a.m.	Break		
11:00 a.m.	Review California Health Care Foundation Health Plan Report and update by Catherine Teare, CHCF	Terry Lewis, Chairperson Catherine Teare, CHCF, <i>Invited</i>	C
11:30 a.m.	Public Comment		
11:40 a.m.	Next Steps/Develop Agenda for Next Meeting	Terry Lewis, Chairperson	
11:50 a.m.	Wrap up: Report Out/ Evaluate Meeting	Terry Lewis, Chairperson	
12:00 p.m.	Adjourn Committee		

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

**Committee Members:**

**Chair:**

Terry Lewis

**Chair-Elect:**

Robert Blackford

**Members:**

Cindy Clafin

Gail Nickerson

Dale Mueller

Josephine Black

Peter Schroeder

Peter Harsch

Steven

Cheryl Treadwell

Melen Vue

Grolnic-McClurg

Deborah Pitts

Daphyne Watson

Vera Calloway

Patricia Bennett

If reasonable accommodations are required, please contact Chamenique Williams at (916) 323-4501 not less than 5 working days prior to the meeting date.

Q      **TAB SECTION**

**DATE OF MEETING**    6/15/16

**MATERIAL  
PREPARED BY:**    Adcock

**DATE MATERIAL  
PREPARED**    5/16/16

<b>AGENDA ITEM:</b>	Overview of San Bernardino County Substance Use Services and Programs
<b>ENCLOSURES:</b>	

**BACKGROUND/DESCRIPTION:**

Veronica Kelly, LCSW, is the Assistant Director for Alcohol and other Drug Programs at the San Bernardino County Department of Behavioral Health. Ms. Kelly is also the Co-Chairperson of the Substance Abuse Prevention and Treatment committee of the County Behavioral Health Directors Association.

In continuing the Council's education around substance use disorders, Ms. Kelly will present regarding the current standards of care for substance use disorders for the public behavioral health system as well as programs in San Bernardino County that serve co-occurring disorders. She will explain how the integration of services occurs and address programs serving youth with substance abuse needs.

Excerpt from website

The San Bernardino County Department of Behavioral Health, Alcohol and Drug Services provides a full range of substance abuse treatment services for San Bernardino County communities and residents.

- Prevention, outpatient and residential programs are offered in every significant population center in the County through contracts with community based organizations and County-operated clinics.
- Detoxification is available for men and women over age 18.

- Residential treatment is offered for men, and women over age 18, and men or women with children under age 5.
- Outpatient services are offered for men, women, and adolescents (persons aged 12 - 21).
- Perinatal services are available in both residential and outpatient programs for women who are pregnant and/or have children under age 5.
- Services are also provided for county residents referred from the Parolee Services Network (PSN), CalWORKs, Proposition 36, Drug Court and the Department of Children's Services (DCS).
- Treatment is available to all County residents regardless of race, religion, gender, sexual orientation, or disability, including chronic illness or HIV.
- The cost of treatment is based on a sliding scale fee according to the clients' income. Medi-Cal and other public assistance funding may pay for some of the treatment; please call for further details.

## **ALCOHOL AND DRUG SERVICE PROVIDERS LIST**

### Department of Behavioral Health

**1.Residential**

**2.Adults With Children Residential**

**3.Adult ODF**

**4.Adolescent ODF**

**5.Detox**

**6.Perinatal**

**7.Recovery Center/Aftercare**

**8.Narcotic Treatment Program**

**9.DUI**

**10.DEJ**

**11.Environmental Prevention**

**12.Drug Court**

**Revised 03/01/16**

R   TAB SECTION

DATE OF MEETING 6/15/16

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/14/16

<b>AGENDA ITEM:</b>	Approval of Minutes from April 2016 meeting
<b>ENCLOSURES:</b>	Draft Minutes of the April 2016 meeting

**BACKGROUND/DESCRIPTION:**

Attached are the draft minutes from the April 2016 meeting of the California Mental Health Planning Council for member review and approval.

# CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

April 20, 21, 22, 2016  
Holiday Inn Golden Gateway  
1500 Van Ness Avenue  
San Francisco, CA 94109

## CMHPC Members Present:

Josephine Black, Chair	Dale Mueller, Ed.D.
Susan Wilson, Chair-Elect	Adam Nelson, M.D.
Robert Blackford	Noel O'Neill
Vera Calloway	Gail Nickerson
Amy Eargle, Ph.D.	Maya Petties, Psy.D.
Lorraine Flores	Darlene Prettyman
Steven Grolnic-McClurg	Peter Schroeder
Peter Harsch	Daphne Shaw
Celeste Hunter	Walter Shwe
Steve Leoni	Cheryl Treadwell
Carmen Lee	Arden Tucker
Terry Lewis	Melen Vue
Esmeralda Liberato	Monica Wilson, Ph.D.
Barbara Mitchell	
Raja Mitry	

## Staff Present:

Jane Adcock, Executive Officer	Tracy Thompson
Linda Dickerson	Chamenique Williams
Tamara Jones	Dorinda Wiseman
Tom Orrock	

## Wednesday, April 20, 2016

### 1. Welcome and Introductions

Chair Black called the meeting to order. The Council members, staff, and speakers introduced themselves.

Executive Officer Adcock recognized Vera Calloway and Peter Schroeder as new CMHPC members. She introduced Professor Matsumoto and her son, visiting from Japan to observe the Council.

### 2. Opening Remarks

Jan Cobaleda-Kegler, Adult Mental Health Program Chief in Contra Costa County, spoke about county initiatives for improving care of consumers and families.

- She described the regions of the county, which is experiencing a housing boom.
- Each region has a children's clinic and an adult clinic. The county is trying to connect the two.
- With the implementation of the Affordable Care Act (ACA) two years ago, enrollment has risen from 10,000 to 14,000.
- Innovation, compassionate care, and commitment to effective care are the guiding principles helping the county to navigate minefields.
- The county is committed to integrated health care across all the domains.
- Care Connect is a project that looks at high volume users of the emergency room instead of the health care system.
- A new children's clinic has opened in Antioch, providing behavioral health as well as primary care services.
- The Coaching to Wellness pilot uses peer providers as wellness coaches, with a ratio of about 1½ nurses to 3 peer providers.
- Assisted Outpatient Treatment is new and provides a whole new way of looking at helping people.
- Evidence-based practices are a win-win: they help train the providers and consumers benefit. The challenge is implementing them. The county is further along in the children's system than the adult system.
- T2 – Trauma Transformed – is a collaborative among six Bay Area counties in which all staff is trained and benefits from what other people are doing.
- David Seidner, LMFT, Program Manager for Forensics Mental Health, spoke about the Crisis Prevention Institute.
  - It ensures that the consumer has a safe environment for care. It sets a standard practice of appropriately and consistently responding to behavior symptoms.
  - The focus is the clinical presentation; any administrative barrier needs to be extinguished.
  - The west part of the county is impacted by intergenerational poverty. The central part is more established suburbia. The south part is a bedroom community to the Silicon Valley. The east part has expanded rapidly in population beginning in the 90s, but it lacks infrastructure.
  - Poverty is not a driver of violence, and weapons confiscation happens in all parts of the county.

Ms. Tucker asked about continuity of care for clients coming from elsewhere. Mr. Seidner replied that staff contacts former providers about successes from the past.

- SB 82 is the funding for the county to have alternative responses to crisis, as well as increases in crisis residential beds.
- Mr. Seidner described how staff responds to crises in homes, including the involvement of peace officers.

Mr. Leoni felt that the way Mr. Seidner was describing the evaluation of acuity to be intrusive and self-confident. He was doubtful about heavy reliance on the police. Mr. Seidner replied that the clinician makes first contact with the consumer, and that police officers are not in uniform. The process of assessment and drawing conclusions is actually slow and gradual. He also mentioned that the implication that mental illness is highly correlated with violence is a stigma that staff is fighting.

Mr. Leoni asked about peers on the teams. Mr. Seidner replied that he uses two peer specialists, who come after other team members have established rapport.

- The mental health evaluation team does voluntary services with people on felony probation.

### **3. Council Questions and Discussion**

Ms. Prettyman asked about follow-up with families as well as with clients, and about family involvement in clients' treatment. Mr. Seidner responded that the National Alliance on Mental Illness (NAMI) is very active in the county, as is Al-Anon. In an optimal situation, the team is facilitating discussion in the household.

Ms. Lee asked if the county uses electronic records to help as clients move around. Ms. Cobaleda-Kegler replied that Contra Costa County is the last county in California not to have electronic health records in its outpatient mental health clinics.

Ms. Lee asked if the program is being fashioned after the PERT program in San Diego. Mr. Seidner replied that while PERT is a first-responding team, his team is more of a secondary responding team.

Ms. Mitchell asked about the cost of police officer personnel versus clinical personnel. Mr. Seidner answered that the Police Chiefs Association got funding through Governor Brown's AB 109 while Contra Costa County is a grantee for SB 82. He described funding of the marked and unmarked vehicles used.

Ms. Lewis voiced agreement with Ms. Prettyman on the importance of family involvement. Providing resources as part of the first response is important.

Ms. Tucker asked how they obtain feedback from consumers. Mr. Seidner replied that there is a written consumer survey that goes to the behavioral health administration. Also, the data supports lots of engagement through which consumers hear about the various services. The team provides expedited services on the spot – at the time the consumers say they are ready.

Ms. Flores asked about performance measurements; how does the mental health evaluation team know they are being successful? Ms. Seidner answered that they use the law enforcement matrix – type of call for service and impact to the police departments. On the clinical side they look at acceptance of the mental health system – use of

outpatient routine care, scheduling appointments, prescription data, service utilization, and decreased police contact.

Ms. Vue asked about the process for responding to multicultural communities or monolingual families. Mr. Seidner answered that in a pinch, they use interpreters on the spot. They also use Southeast Asian Mental Health.

Ms. Calloway asked about any utilization of community groups and workers in terms of prevention and education, as opposed to the police force. Mr. Seidner responded that during police force trainings, they seek to decriminalize a behavioral emergency – to change the mind of one officer at a time. Also, in presentations to community groups, they try to take on mental health first aid. Last, their optimal goal is getting the patient to participate voluntarily in outpatient routine care.

Mr. Seidner stated that in Contra Costa County, they feel that the interaction with the community is rigorous and important. He asked the CMHPC to continue to poke holes in any program that he puts forward, because you are making the process better.

#### **4. Approval of Minutes from January 2016 Meeting**

Mr. Leoni requested a change on page 17.

**Motion:** Lorraine Flores moved to accept the January Minutes as corrected; seconded by Raja Mitry. Motion carried with Ms. Wilson, Ms. Mitchell, and Mr. Harsch abstaining.

#### **5. Public Comment**

John Black, former CMHPC member, spoke about the Stanislaus County Art Recovery Project. It is a thriving community-based program in every sense. He stated that mental health clients are no longer in a segregated society – they need to be fully integrated into the community. He also spoke about the success of the Workforce Education and Training (WET) program in Modesto.

#### **6. Marijuana Legalization: Implications for the Public Behavioral Health Treatment System in California**

Peter Banys, M.D., MSc, gave the presentation for the Council.

- People are beginning to repudiate the official versions of many of the key aspects of the War on Drugs. The shift is from a criminal model to a public health model.
- Other countries have made a distinction between hard and soft drugs.
- Dr. Banys made the case that in California, we have to pay special attention to the vulnerability of juveniles.
- Cannabis is the front edge of the paradigm shift in the War on Drugs.
- In the United States, drug enforcement has been tied to political agendas for a long time.
- For the last five years, more than half of Americans have supported marijuana legalization. This is a signal of what is happening on the ground.

- One of Dr. Banys' theses is that the healthcare industry (treatment) competes for the same raw materials for processing (drug users) as the incarceration industry (criminal justice).
- Incarceration is a growth industry. The U.S. rate of incarceration is extremely high compared to other countries.
- Arrests predominate for possession of marijuana rather than for distribution/manufacture/sale.
- Incarcerating a person for one year in California is very expensive: \$64,000. Proposition 47 is trying to address this in changing the criteria for incarcerating people.
- Nothing we can do will stop the international production and smuggling of drugs. The industry is organized and has virtually taken over parts of countries such as Mexico.
- Polls suggest that the state of California is going to endorse a legal initiative in November by about 56%. When it does, the entrepreneurs will be all over it.
- The vulnerable group is kids. High schoolers who are regular users have the highest risk of dropping out of school, having poor grades, and having problems in performance.
- Since 2009, more 18-year-olds smoke marijuana than cigarettes.
- Marijuana is perceived as safer than cigarettes.
- Today in California, 151,000 high school students are using marijuana between 10 and 30 days per month.
- Dr. Banys feels that the harms of marijuana use are more to school-age learning than to addiction.
- If a person is vulnerable, marijuana can double the risk for having an onset of psychotic symptoms.
- The earlier the age of onset of use, the more vulnerable the person is to early addiction.
- Persistent marijuana use is correlated with an impairment in cognitive ability.
- Dr. Banys believes that we should put tax revenue into two places: the school system for student assistance programs, and public sector treatment for kids.
- Risks to educational progress are serious: cognitive inefficiency, poorer academic performance, higher rates of school dropout, and associated behavioral and family problems.
- For kids, legal harms of cannabis criminalization include criminal arrest records, probation, and juvenile hall.
- California has been trying to reduce the zero-tolerance policies in schools.

- Juvenile felony arrests are now about half possession and half sales.
- It is difficult to understand the legal difference between misdemeanors and infractions.
- Implications for public policy are:
  - Work with legislators and write legislation.
  - Utilize school-based student assistance programs.
  - Utilize community-based treatment programs.
  - Rationalize and properly medicalize the medical marijuana system.
  - Do more long-term research when marijuana goes legal.
- Because kids are the vulnerable group, we should aim our resources toward them. Delay their marijuana use and identify them when they are in trouble to provide remediation.
- Dr. Banys is more interested in remediation than prevention – Just Say No and DARE programs haven't worked.
- Dr. Banys' recommendations are:
  - Eliminate zero-tolerance school policies for simple possession.
  - Train new staff for student assistance programs. Engage parents.
  - Clarify possession charges.
  - Track juvenile possession infraction arrests.
  - Analyze and track upcharging.
  - Analyze outcomes of the treatment side and the incarceration side.
  - Dr. Banys felt that the Adult Use of Marijuana (AUMA) Advisory Board is tilted toward the industry. We need to get more providers represented on the board.
  - The Department of Health Care Services (DHCS) needs a second advisory board.
  - Keep medical and recreational dispensaries separate.
  - Convert doctor marijuana recommendations to prescriptions.
  - Track all medical marijuana prescriptions in the CURES database.
  - For youth medical marijuana prescriptions, require a second medical opinion and parental notification.
- Dr. Banys urged the CMHPC to consider building consortiums and coalitions of like-minded mental health providers to design a community-based treatment system for kids, as well as a school-based system with liaisons for mental health

care in the community. This needs to be done before AUMA passes in November. Staff and programs need to be placed in specific locations.

### **Questions and Discussion**

Ms. Mitchell mentioned that low-income people in federal and Section 8 housing cannot smoke marijuana in the building or in a public place. The result is that they can only use edibles which are very expensive. Furthermore, the local hospital in Monterey County has found a high number of previously stable people developing psychotic symptomatology, and testing positive for high cannabis levels. Dr. Banys responded that in the United States marijuana has a very high potency which is going into edibles. As a selected population, people living in supported housing are likely more vulnerable to psychosis. Dr. Banys said that the exact story is evolving in real time; we don't know enough about it yet. The same is true for intoxicated driving.

Dr. Nelson spoke of the psychosis in young people he has been seeing recently; he believes that there is a particular psychotic syndrome that affects people with heavy marijuana use who are uniquely at risk. Dr. Nelson recommended including as a uniquely vulnerable population not just youth, but also people with mental illness or family histories of it. Dr. Banys responded that for a lobbying posture for resources, everyone wants to help kids as opposed to adults. The psychosis rates in adults are very low.

Dr. Banys felt that legislators take no interest in patients in private practice. They will take interest in an increasing recidivism rate that is sending relapsing people back into public sector hospitals.

Mr. O'Neill mentioned Ralph Cantor, an educator who speaks in schools about the brain chemistry of adolescents using marijuana. Dr. Banys was in favor of prevention and education, but stated that much of the talk about myelination and brain development is more metaphor than science at present.

Mr. O'Neill agreed about not criminalizing youth who use marijuana, but instead providing intervention. What the Planning Council can do is to work with DHCS to insist that treatment for youth be included in Drug Medi-Cal. Dr. Banys commented that the federal and the state having substance abuse and mental health in separate boxes has made reimbursement very hard. Doing substance abuse work with adolescents and others is a legitimate part of mental health and vice versa.

Ms. Flores stated that the biggest issue in getting homeless youth with mental health issues into services is when they are medical marijuana users. Dr. Banys agreed and stated that we need to increase the regulation on medical marijuana – making it an actual prescription system.

### **7. Public Comment**

There was no public comment.

## **Thursday, April 21, 2016**

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

Chair Black welcomed everyone to the second day of the general meeting. Those present introduced themselves.

### **2. Critical Role of Families in Preventing Risk & Promoting Well-Being for LGBT Youth**

Dr. Caitlin Ryan, Director of the Family Acceptance Project in San Francisco and a clinical social worker, spoke about a prevention and an intervention approach that can have a profound impact on LGBT young people and their families, as well as our communities.

- All of the project's research, intervention, and early development work was done in urban, rural, and suburban areas of California.
- LGBT young people often feel a lack of hope, especially if they come from a conservative background.
- Lesbian, gay, and bisexual adolescents are about three to four times more likely to attempt suicide than their heterosexual peers.
- There is an important movement underway to include sexual orientation and gender identity in death records.
- About 40% of homeless young people are LGBT.
- Kids are self-discovering at younger ages, which increases likelihood of victimization, harassment, or badgering by family.
- The term "transgender" didn't start to become widely used until around 2005. The concept of transgender is missing from much of the early research.
- On average, kids have an internal sense of their gender at around age three. We need to deal with this as part of early childhood development and elementary school.
- Historically, families were seen as adversaries of LGBT children. We need a family-based approach for children coming out. The typical institutions that serve children and adolescents are not serving the socially diverse families from which these children are emerging.
- With Raphael Diaz, Dr. Ryan started the first project that would develop foundational research – a new framework for education and training – for a family-based approach to wellness prevention and care. It would change the way services are provided.
  - The researchers framed the project from a perspective not of morality, but of health and well-being.
  - They wanted the diverse families to learn to support their children, help keep them with their families, reconnect them if necessary, and help

promote permanency – and to do so in the context of their families, faith traditions, and cultures.

- The researchers went all over the state for interviews, which were 2-4 hours long. They ended up with about 8,000 pages of transcripts.
- They identified 106 accepting and rejecting behaviors that came out of the lived experiences.
- They did the work in English, Spanish and Chinese, on people with many different kinds of backgrounds.
- They found that when they presented the information in a way that the families could hear it, it made a difference.
- The behavior measurements showed that young adults from families that were not at all accepting during adolescence had a 60% change of taking their lives by young adulthood. A little bit of acceptance started to change the numbers.
- High levels of rejection during adolescence were related to a more than six times greater likelihood of clinical depression as a young adult. Moderate levels of rejection would cut the likelihood in half.
- Young people who experienced homegrown conversion therapy were at much higher risk.
- As families engaged in accepting behaviors, the sense of the future changed for the young person.
- Rejection is linked with serious health and mental health problems, and acceptance is an important factor and helps promote well-being.
- The researchers have developed tools:
  - a family intervention model with a series of strategies
  - various resources such as the family video stories
  - use of social learning theory
  - faith-based curricula and materials
  - extensive provider training
  - assessment tools
  - multilingual family education booklets
  - a risk assessment screening tool
- Providers need to make a conceptual shift to see families as allies, not adversaries – helping them understand that parents and caregivers can support their LGBT children via simple behaviors, and that rejecting behaviors are typically motivated by trying to help their child.

- Families are a low-cost, low-tech, culturally congruent option for mental health – with potential outcomes for building civil society.
- Dr. Ryan showed one of the family intervention films.

### **Questions and Discussion**

Ms. Mitchell asked if the video is available in Spanish. Dr. Ryan answered that it soon would be – she had paid for it herself.

Mr. Mitry asked about the outreach to identify and engage the families; and how did Dr. Ryan overcome initial barriers by families to be interviewed? Dr. Ryan answered that she has been working for many years in many cultures. She would request to hear their side of the story, which was hard for people to resist. Many families had never had an opportunity to tell their story to a nonjudgmental person.

Mr. Mitry mentioned deaf and hard-of-hearing LGBT individuals and families. Dr. Ryan responded that they are included in the study, as well as individuals with chronic mental illness, behavioral and health concerns, developmental disabilities, etc.

Ms. Tucker thanked Dr. Ryan for portraying a family of color. Dr. Ryan affirmed that it is a cultural story as well.

Mr. Leoni thanked Dr. Ryan for being a pioneer modeling this kind of dialogue and technique for the rest of us.

### **3. Public Comment**

There was no public comment.

### **4. Report from California Behavioral Health Directors Association**

Mr. O’Neill reported on the following activities.

- The California Behavioral Health Directors Association (CBHDA) is working on establishing a permanent base and growth for the 2011 Realignment.
- All of the counties are working on the May Mental Health Month event on the 24<sup>th</sup> with local activities.
- CBHDA is now fully staffed, which is critical when necessary legislative changes have been identified.
- As the state moves toward reforming the way foster children receive services, treatment for mental health concerns or alcohol and other drug concerns plays an important role.
- Legislation on housing is currently being formed. CBHDA has developed a set of principles endorsed by a number of different organizations. A safe place to call home is essential for personal recovery and wellness, and behavioral health services are critical in preventing homelessness. The principles are:
  1. Utilize the public behavioral health target population definition for homelessness prevention and reduction efforts.

2. Utilize strategies that prevent homelessness.
3. Utilize proven models to respond to homelessness.
4. Invest in supportive services and break the cycle of long-term homelessness.
5. Fund construction, supportive care, and subsidies for those living in the house.
6. Ensure that residents of all counties can benefit from additional housing investments.
7. Balance the investment so that some money is available for housing and some for direct services.
8. Consider the volatility of MHSA revenue.
9. Ensure flexibility to address local needs.
10. If legislation is passed, it needs to address the NIMBYism (Not In My Back Yard) issue.
11. Leverage and increase the impact of existing and emerging state housing and services with any local matches.

### **Questions and Discussion**

Mr. Mitry asked what is different about this that will take it to the next level. Mr. O'Neill felt Darrell Steinberg would say that in the MHSA housing element, there was \$400 million available that was matched with California Housing Finance Agency (CalHFA); in this vision the revenue would be \$2 billion. The bill itself has not been written – there are opportunities for input.

Ms. Lee spoke of the crisis in San Mateo County in housing costs and eviction rates. Section 8 is basically inactive. People with mental health conditions are moving 60-70 miles away from their doctors and support systems. Mr. O'Neill responded that the Mental Health Director in San Mateo County, Steve Kaplan, is very concerned and is advocating about this very problem.

Mr. Grolnic-McClurg commented that in Berkeley the crisis is similar. He felt that using MHSA money to fund a bond is incredibly poor decision-making, considering the California economy's boom and bust cycles.

Ms. Mitchell commented that the biggest problem in housing development is that the federal government stopped funding project-based housing and decided that the private market could take care of it. The trend has been towards pushing the money into the private sector by putting out Section 8 vouchers. In poor economic times, landlords jump at this, but in good economic times they reject it. Ms. Mitchell stated that the only way for this to work is that all the housing must be owned and controlled by either a governmental entity or a nonprofit, forever.

Mr. O'Neill commented that MHSA was never intended to solve the homeless problem in the state. We want to focus on those persons who have chronic and serious mental illness

– that was always the intent, but somehow there is the thought that MHSA is going to be the magic solution to eliminate this problem.

Mr. Leoni commented that in terms of competitive grants, every county should get something, but at the same time money should not be released until the proposal is fully developed. He asked about SB 614: DHCS has recently released a virtual gutting of the bill. He was hoping that CBHDA, which has exhibited a lot of support for the client movement and for this issue, can find a way to negotiate creatively with DHCS.

Mr. O’Neill responded that CBHDA is committed to SB 614. They understand that the State Plan Amendment triggers Proposition 30.

Executive Officer Adcock reported that today there was to have been a meeting in the Senate Health Budget Subcommittee regarding the housing bond proposal. It has been cancelled. The decision has been made to bring it to the full Budget Committee with the hearing to take place in May. Staff says they are taking the submitted suggestions and issues into account as they develop the details.

## **5. Executive Officer’s Report**

Executive Officer Adcock reported that on March 9, the Senate Committee on Health held a hearing about Mental Health Workforce. They had three panels, with the CMHPC participating in one. The issue was the workforce shortage and any mitigation strategies. Executive Officer Adcock and Cindy Claflin spoke on the CMHPC’s role in the OSHPD Five-Year Plan, and Executive Officer Adcock informed the committee on the CMHPC’s long history regarding workforce. The Senators had been interested in why professionals either do not go into the mental health profession or do not stay.

Committee staff had a follow-up meeting with Executive Officer Adcock and Ms. Wiseman to go over Council recommendations. At the top of the list was continuing statewide WET dollars, administered by OSHPD, beyond FY 17-18.

Staff member Tom Orrock is going to be staffing the Workforce Ad Hoc. Any interested Council members can join. The first priority is to advocate and create action forward for the continuation of the WET dollars.

Executive Officer Adcock also reported that the Little Hoover Commission has found in a one-year follow-up, that none of the recommendations from their 2015 MHSA report have been implemented. They are holding another hearing on May 26 from 9:30-12:30.

The CMHPC has been invited to present and be part of the hearing. Executive Officer Adcock and Ms. Shaw will present.

Executive Officer Adcock and Ms. Wiseman have begun efforts to get the statutory changes for the CMHPC’s name change. They are dealing with a Republican consultant who feels that the CMHPC’s name change would be more than just technical – that it would be expanding the CMHPC’s scope.

Ms. Flores commented that as a nonprofit, her group is also experiencing significant vacancies and trying to find qualified people. There seems to be a real difference between people who joined the field 20-30 years ago, and younger social workers and

MFTs who are more focused on their career and movement up, and less so on the mission.

Executive Officer Adcock added that the millennial generation appears more motivated not by money but by a life/work balance. We need to create situations that are more appropriate to this generation's perspective.

Mr. Leoni commented that all young people are very experimental; this may not be a permanent characteristic of the millennials. He also commented that this is a generation of college students and graduates who are looking at astronomical amounts of money to fund their education. This could be part of their motivation not to stay at the same jobs.

Ms. Tucker spoke about her years earning her Bachelor's and Master's degrees, during which no one took her up on her offers to share about the bipolar experience.

## **6. Committee Reports – Patients' Rights, Health Care Integration, Continuous System Improvement, and Advocacy**

### **Patients' Rights Committee**

Committee Chair Daphne Shaw reported on the following.

- The committee is about to complete the project to inform the Mental Health Boards and Commissions on patient rights in their counties. The committee is sending out letters to the Mental Health Board Chairs, asking them to agendaize an item on patient rights.
- The committee has been receiving the feedback that with the huge increase in competency hearings, Patient Rights Advocates spend the majority of their time on those and do not have the time available to perform the other requirements.

The committee is working on how to expand the number of Patient Rights Advocates in the state, in order to advise DHCS.

Ms. Shaw and Executive Officer Adcock will be speaking on this issue at the next meeting of the California Association of Mental Health Patients' Rights Advocates (CAMHPRA).

- Dr. Petties, who works at Patton State Hospital, had shared at the meeting regarding the processes relating to patient rights at the hospitals.

Mr. Mity expressed the hope that as the committee tries to expand the number of Patient Rights Advocates, they will encourage a greater sense of cultural and linguistic responsiveness and awareness. Our constituents are very diverse.

Mr. Blackford asked if there are peers functioning as advocates. Ms. Shaw replied that there are many counties that have them.

### **Health Care Integration Committee**

Mr. Blackford reported on the following.

- During the committee meeting, Dr. Penelope Knapp and Dr. Robert Horst reported on the state of the art in terms of ensuring that kids are not

overmedicated, available evidence-based practices, and challenges. With the theme for the year of children and adolescents, the committee is looking at medications and how they are used and misused.

- Mr. Grolnic-McClurg stated that the committee is partnering with the California Health Care Foundation (CHCF) which is producing a report on the Mild-to-Moderate benefit; the committee will include it as a work product for the year.

The CHCF produced a *Mental Health Almanac* in 2013. They want to utilize the CMHPC in order to get more consumer and family member feedback into the data they produce. Mr. Grolnic-McClurg asked if the Continuous System Improvement Committee would be interested; Ms. Wilson, Ms. Flores, and Ms. Dickerson agreed to take a look. Ms. Prettyman also volunteered.

### **Continuous System Improvement Committee**

Committee Chair Lorraine Flores reported on the following.

- Ms. Wilson and Ms. Dickerson have been working on the *Data Notebook*, which is shaping up into a fine format.
- Ms. Wilson reported that this year the *Data Notebook* centers on children's issues. It will have nine or ten specific questions. The committee is waiting for data from DHCS on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which will be aggregated for the small counties.
- The committee is also working closely with the CBHDA on their data that looks at MHSA dollars and Full Service Partnerships; they have some specific to children and youth.
- Where specific data is lacking for a local Mental Health Board to look at, the *Data Notebook* will include one-paragraph research narratives on the topic (for example, Juvenile Justice).
- Ms. Flores said that Dr. Ryan had spoken to the committee. She noted that in Santa Clara County, there has been a huge upsurge in LGBT homeless youth. There must be interventions and prevention services as well as services to identify what is going on with these youth and their families. Ms. Flores' agency, and the county, are seeing that this is a systems approach to prevention – working with families.

Ms. Flores asked the Council members for feedback on Dr. Ryan's presentation.

Mr. Mitry responded that the film in particular had been very moving. Hearing about the lived experiences has impact.

Dr. Petties commented that many people working in the mental health field had not received training in this area. Having more people exposed to this information benefits everyone.

Ms. Treadwell found the information regarding conservative thinking and the church perspective to be eye-opening. The message of hope, well-being, and behaviors was very compelling.

Dr. Wilson found the information phenomenal because it touched on what really happens in family dynamics. She appreciated the research done over time showing how the community is evolving to understand that this population needs to be embraced with a focus on family.

Ms. Wilson had been pleasantly surprised by the inclusiveness: language access, cultural access, access for people with hearing loss, and so on.

Ms. Shaw asked for Dr. Ryan's PowerPoint presentation.

### **Advocacy Committee**

Committee Chair Darlene Prettyman reported on the committee's four goals.

1. Report on logistical, fiscal, and programmatic efforts being made to transition people out of institutions for mental disease (IMDs). If none are being done, what are the challenges? The completion date is scheduled for January 2017.
2. Look into the closure of residential care facilities in California. Ms. Prettyman commented that for her, "residential care" is synonymous with "board and care." Ms. Wiseman is looking for qualitative rather than quantitative data. The draft completion date is scheduled for October 2016.
3. Follow up on the report of the implementation of AB 109 Criminal Justice Realignment. Ms. Wiseman has met with San Mateo, Los Angeles, Stanislaus, and Santa Clara Counties, and will be asking them specific questions relative to AB 109, looking for current status and future outlooks. The estimated completion date is October 2016.
4. The committee had heard a presentation from Stephanie Welch, now working as Executive Officer at the Council on Mentally Ill Offenders (COMIO). This year the committee is working on the juvenile justice system dealing with teenage youth, and they will be collaborating with Ms. Welch on prevention of juvenile delinquency. No completion date has been established for this new goal.

The committee also has a huge legislative agenda. They are working on ways to approach the legislative process so they can have information prior to their meetings.

The committee is changing the wording from "mandatory or discretionary platform" to "policy platform."

Ms. Shaw added that the committee had taken an opposed position to a NIMBY bill.

Executive Officer Adcock invited the Council to share impressions of the meeting with the professor from Japan the previous night. The professor had asked what the Council would hope for in the world of mental health. Executive Officer Adcock had answered that the Council would like to see the general reaction to mental illness in an individual to be like the reaction to diabetes – no one would mind having a person with mental illness for a neighbor, an employee, a teacher, and so on.

Ms. Lee appreciated finding out more about the other consumers in the room, and hearing the professor say that 20 years from now, Japan would be like California.

Mr. Leoni commented that it was interesting to delve into the real meaning of commonly used terms such as “lived experience.”

Ms. Liberato appreciated the professor’s interest in each consumer’s story.

Ms. Calloway commented that she will have a positive report to make for the NAMI Japanese group in Los Angeles. She agreed with the assessment that Japan is about 20 years behind California.

Ms. Tucker commented on cultural competence: she had appreciated hearing from a person of color from the other side of the globe. She had also appreciated the professor’s receptivity and excitement to learn more and take it back with her.

Chair Black had felt concern about the Loan Assumption Program being termed a success in the system. She would be interested in hearing about future progress in Japan. Chair Black had also appreciated Executive Officer Adcock’s ability to articulate concepts for the translator that the Council was touching on.

Mr. Mitry wondered how the term “consumer” translates into Japanese. Executive Officer Adcock noted that at lunch, she had discussed the term “person with lived experience” with the professor.

Mr. Leoni commented that the term “consumer” as used in mental health had been invented by consumers themselves.

Ms. Lee commented that she had asked if suicide was still considered honorable, and the professor had replied that it has changed; it is not looked on positively anymore.

## **7. Public Comment**

There was no public comment.

## **Friday, April 22, 2016**

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

Executive Officer Adcock stated that Council member Robbie Powelson has departed the CMHPC.

Chair Black welcomed everyone to the last day’s meeting and had them introduce themselves.

### **2. Welcoming Remarks**

(Senator Mark Leno could not appear.)

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

Dr. Larry Gasco, President of the California Association of Local Behavioral Health Boards/Commissions (CALMHB/C), reported to the Council.

Dr. Gasco noted that because of financial constraints, the number of CALMHB/C attendees at this meeting was low. However, he emphasized the importance of CALMHB/C's collaboration with the CMHPC.

CALMHB/C consists of 25 directors representing 21 counties. The counties not represented may not be getting the support they need.

- In October, CALMHB/C members approved a *Policies and Procedures* manual.
- In addition to working on its infrastructure, CALMHB/C is working on not being dependent on only one source of revenue only (i.e., the Mental Health Services Oversight and Accountability Commission [MHSOAC])

Ms. Lee asked what it takes to get a county to finance a representative on CALMHB/C. Dr. Gasco responded that CALMHB/C requests dues of \$500 on a voluntary basis. All of the five state regions elect five Directors to this 25-member board.

Ms. Shaw stated that the CMHPC is mandated to have a Patients' Rights Committee. Last year this committee had sent a letter to the Mental Health Board chairs, asking them to agendaize an item on patient rights. Only four counties had responded. The committee is now going to send a paper letter to each director's office, in the hopes that it will get into the hands of the chair to be presented at Executive Committee meetings. Ms. Shaw asked for Dr. Gasco's assistance through CALMHB/C in this effort.

Dr. Gasco suggested for Ms. Shaw to make a presentation at a CALMHB/C meeting. Ms. Shaw requested for Dr. Gasco to make mention of the upcoming letter at the CALMHB/C meeting.

#### **(7.) Planning Council Behavioral Health Integration Discussion**

Executive Officer Adcock stated that membership in the Behavioral Health Steering Committee is open. The committee meets monthly with Bruce Emery, the Technical Consultant assigned by the Substance Abuse & Mental Health Services Administration (SAMHSA).

Executive Officer Adcock noted that with the stall of the CMHPC name change in the Welfare and Institutions Code, she hesitated to make official moves. However, the Council could continue with education and information gathering.

Ms. Wilson stated that 19 Planning Council members had answered the survey sent by the Steering Committee, giving ideas for direction. She felt it important to make sure that all members are part of this effort.

The survey results showed that the top two areas of interest had pertained to the service system, and the overview of co-occurring causes/treatment and key state and national players.

Ms. Wilson asked the Council about the California system for individuals with co-occurring disorders; it has always been a separate system from mental health. The Steering Committee sought feedback from the Council on what they want to know about the system.

Mr. Leoni pointed out that the term “co-occurring” needs to be clarified. He noted that historically, it was mental health providers rather than the substance abuse side who took on the people with co-occurring disorders.

Mr. Leoni also pointed out that the system of delivery is undergoing a radical change with the Waiver and the switch to the counties. We need to update ourselves on that.

Ms. Wilson displayed and discussed the results of the survey.

She asked those present to add to the list of priorities for education and training.

- Importance of family and support systems
- Health plan and insurance network adequacy
- Veterans with PTSD – treatment needs different from other trauma co-occurring disorders
- Cultural beliefs and approaches to substance use
- Detailed discussion of substance use disorder and mental illness treatment approaches dissimilar under California rules and regulations
- Clarity regarding how new federal health care laws impact delivery of services at the local level

Ms. Mitchell suggested regulatory issues around alcohol and drug licensing certification – how this is working under the new system. How do they operate; how do they lobby?

Mr. O’Neill noted that in actuality, most counties are entirely integrated – not just co-occurring, but the entire system. Regarding the Waiver coming up: the substance use system has not been a managed care system the way mental health has been. That will change in October. One of the big changes on the horizon, especially for small counties, will be the networks. In the Superior region they are working closely with Partnership Health; small counties cannot meet the standards of the organized delivery system waiver alone. This will create new services in areas that have not had services.

Mr. O’Neill suggested having a presentation at the Council’s June meeting from the CBHDA Chair of the Substance Abuse Treatment Program Committee.

Mr. Leoni suggested learning more about the advocacy community within substance use. That community and the mental health advocacy community really have yet to talk to each other.

Ms. Wilson asked for further specific thoughts from the Council on what would meet their needs.

Ms. Lee wanted to see what substance use does to a person with mental health challenges, including interactions with certain psych drugs.

Ms. Prettyman agreed with Mr. Leoni that the advocacy groups for substance use and straight mental health do not mingle. There is a strong concern about money: which side is it going to go for?

Ms. Prettyman also wished to hear from the CBHDA Chair of the Substance Abuse Treatment Program Committee about treatment for co-occurring illnesses – what kind of groups they run, what kind of education they have.

Ms. Mueller noted that Bruce Emery may have recommendations to build on. Executive Officer Adcock responded that although other states may have widely established professional organizations for the substance abuse providers, California does not have any that the Council knows about yet. However, the process and issues that California will encounter are similar across the states; that is what Mr. Emery has been helping with.

Dr. Petties suggested as a resource Dr. Freimuth, the former director of the Patton State Hospital Recovery Lifestyles program which has been very successful.

Mr. O'Neill suggested having the CBHDA speaker give an overview of the private providers, who make up a huge percentage of all substance abuse services. He also suggested an overview of the certification requirements for providers.

Ms. Flores suggested a panel of consumers.

Ms. Prettyman suggested learning about services for Transition-Age Youth (TAY).

Dr. Eargle felt it critical that treatment for co-occurring disorders is integrated. Contracting with a substance abuse provider is great if the provider understands mental illness and understands how substance abuse may be different for people with mental illness. The provider also needs to understand how the triggers of some mental illness symptoms can lead to substance abuse. Dr. Eargle offered to connect CMHPC with trainers at UCLA who are working with Corrections.

Ms. Mitchell felt that the Council should focus on the drug and alcohol system not serving co-existing disorders, because the true co-occurring treatment programs are generally run in the mental health system. Those people qualify as having Serious and Persistent Mental Illness and are billable under the Mental Health option – already Medi-Cal services. Ms. Mitchell added that there are also many more for-profit providers in the substance abuse system which is oriented towards people who don't have co-occurring disorders.

Ms. Wilson agreed about the billing: substance use disorder treatment programs are going to have to acquire the ability to bill insurance companies as well as Medi-Cal.

Mr. Leoni suggested looking at tiered confidentiality going from physical health care to mental health care to substance use care.

Mr. Blackford agreed with Ms. Mitchell – it is essential that we look at the system that just serves substance abuse; the majority of co-occurring is being managed by the county system already.

Ms. Calloway commented that at her Social Services agency, where they specialize in older adults, they have hired a psychiatrist who specializes in addiction because of the

increase they have seen in consumers who are abusing medication. Her name is Dr. Romana Zvereva.

Ms. Prettyman expressed concern about the different styles of treatment between substance abuse and mental health. She also commented that in co-occurring, that are leaving out the persons who are only substance use or only mental illness; in housing, they are putting users in with people who are not users. People with mental illness are very susceptible. Ms. Prettyman noted that tough love treatment does not work with mental illness.

Mr. Harsch commented that it would be interesting to hear from counties with successful models for substance abuse working together with mental health.

Mr. Schroeder mentioned the California Coalition for Whole Health which was formed during the work on the baseline plan for the ACA in California. It is dormant now but the website still exists, including the membership roster.

Ms. Wilson said that hearing about the social determinants of health would be beneficial in this group. Ms. Mueller mentioned that the World Health Organization (WHO) website has abundant resources and is often used as a knowledge base.

Ms. Wilson stated that she liked the idea of a panel of consumers; of having the speaker from the San Bernardino Substance Abuse Treatment Program Committee; and of staying aware of the split between co-occurring disorders and substance abuse only. She said that according to the Council's decision, initially we will focus in on those people with co-occurring disorders.

Mr. Blackford pointed out that focusing on connecting with the community of substance use providers adds to the Council's advocacy – meaning more people have our message and we have their message. He stated that in Michigan, the developmentally disabled are in the same system of care as both substance use disorder and mental illness, and it makes a huge difference for the amount of advocacy and the amount of dollars that are in that system.

Ms. Vue suggested adding a family member to the consumer panel for their perspective and their experience navigating the system.

#### **(unscheduled) Council Member Feedback**

Executive Officer Adcock stated that a few years ago, the Council had restructured its committees. The Council then implemented focus areas. Executive Officer Adcock asked for Council member feedback, as the process is evolving.

Ms. Prettyman asked about the speaker no-shows. Executive Officer Adcock answered the Senator Leno's office had finally responded yesterday, and that up until yesterday Marko Mijic from the Health and Human Services Agency had been confirmed to come. Ms. Prettyman expressed frustration with the situation.

Ms. Prettyman asked regarding the children and youth theme: did the Council ever do the recommendations that were not done under the Master Plan? Executive Officer Adcock replied that we have a bid package that is in the process of being released, so we can solicit a consultant to go through all of the recommendations.

Ms. Prettyman stated that she very much appreciated the committee report template; it is a great tool.

Ms. Prettyman commented that she missed having the CALMHB/C members in the audience. She asked to see their new *Policies and Procedures*.

Ms. Shaw commented that Karen Baylor had not come yesterday, and no one was sent from the Department in her stead; this seemed to indicate the importance of the CMHPC to the Department. Back during the Department of Mental Health years, Steve Mayberg never missed a meeting and always had a worthwhile report.

Mr. Leoni responded that Ms. Baylor was attending a California Institute for Behavioral Health Solutions (CIBHS) meeting that had been scheduled at the same time as this meeting. Ms. Shaw felt that in any case, someone should still have been sent from the Department.

Dr. Wilson agreed with Ms. Shaw's sentiment. Perhaps a letter could be written to the Department, asking for someone to come and give an update on priorities and activities around mental/behavioral health. Executive Officer Adcock said she would draft a letter on behalf of the Council, to be signed by the Chair. The Council members agreed.

Mr. Leoni commented that the real head of things in mental health is the person directing the Department of Public Health. The Mental Health Director is appointed by the Board of Supervisors and is just a bureaucrat. He suggested lobbying to higher-ups on the value of the CMHPC.

Ms. Treadwell felt that a letter was in order to record the Council's position. Ms. Baylor does have a team and someone should be here.

Ms. Shaw noted that now is a critical time for the Department; the state bill had passed regarding federal behavioral health clinics.

Ms. Mueller agreed on the need for a letter requesting a designee if Ms. Baylor could attend the meetings.

Mr. Leoni mentioned that the federal government deadline for the Excellence in Mental Health Act is October – any CMHPC involvement would have to happen very quickly to be effective.

Executive Officer Adcock stated that the Department is holding a Behavioral Health Forum webinar on Monday morning for one hour. She will forward links to the materials for all Council members.

Chair Black asked the members for feedback on the hotel.

Ms. Prettyman had enjoyed the hotel, and asked about affordable restaurants nearby. Chair Black noted that the front desk had a complete list of nearby restaurants. Executive Officer Adcock added that CMHPC staff always does some background research prior to meetings and includes it at the front of the packet.

Ms. Tucker agreed that the budgets of consumers should be kept in mind. She added that the CMHPC is a very welcoming council, but new members may not know where other members are going at lunchtime. She encouraged continuing members to be aware of

new members to ask about lunch plans. Chair Black added that the mentors for new members can also play a role.

Dr. Petties acknowledged the support staff for helping her make her accommodations late. She agreed with Ms. Prettyman that the hotel was very nice and that her room also had a beautiful view.

Ms. Mitchell emphasized the importance of setting timelines to attain the goals that the Council is supposed to be working on: the decision about whether to be an integrated behavioral health council, as well as completion of the projects pertaining to the Mental Health Master Plan cleanup. We're using public dollars here and we should use them wisely.

Mr. Schroeder commented that the public transit options for getting to the hotel were not good. Mr. Leoni agreed. Ms. Lee added that the parking was expensive.

#### **(6.) Public Comment**

There was no public comment.

#### **(4.) Report from Mental Health Services Oversight and Accountability Commission**

Toby Ewing, Director of the MHSOAC, reported to the Council.

At a Budget Hearing yesterday, the MHSOAC had talked with the Legislature about its activities. The Legislature was very interested in oversight for both the Commission and the DHCS.

#### **Fiscal Transparency**

The Commission is putting emphasis on fiscal transparency. They have created a "balance calculator" containing all fiscal data for all of the years, for all of the counties, for each of the components, with room for revenues, expenditures, and balances.

The counties then gave feedback on the best way to describe the information in the Annual Revenue and Expenditure Reports: a sort of checkbook register showing a running balance. The counties cautioned that the register is not really valid and reliable.

The Commission has now stepped back and is looking at the history of this issue. In 2012, the Legislature gave DHCS 14 positions to design a strategy for transparency through the Annual Revenue and Expenditure Reports. DHCS recognizes that the job has not been done in a way that allows people to answer the questions that the Legislature intended.

There is now a tremendous push to complete this task quickly. Many of the counties have already put their reports online; they agree that this is the right thing to do. They are frustrated with the forms, which force the counties to answer questions that are incomplete. Some of the auditor-controllers will not sign off on the forms.

The Commission is holding a public hearing next month to look at reversion policy, in which unspent county money reverts back to the State Fund after three years to be

redistributed to other counties. No dollars have reverted since '08, even though counties have not spent their money within the three-year timeframe.

The Commission considers the situation a mismatch of policy and practice that has not been updated after the State changed the way dollars flow. Mr. Ewing expressed the hope that the CMHPC would participate with the Commission in this task.

### **Regulations**

The Commission is also working on its regulations. The counties had reported that there were three issues that concerned them:

- The requirement for an Access and Linkage Program
- The requirement to report on the duration of untreated mental illness
- The requirement to track detailed demographic information

Mr. Ewing said that many people, particularly in the more rural counties, have suggested that gathering information on sexuality is going to violate the safety and security of the clinical relationship. Some Bay Area people noted that they have been collecting that information for quite some time, and found that it is actually staff who are uncomfortable, not consumers. They suggested training/support at the provider level.

### **Programmatic Reviews**

The Commission also has a series of programmatic reviews in progress. It started with a project begun last year on crisis services for children and youth. The Commission held hearings in San Francisco and Santa Barbara, did site visits, had advisory committee meetings, and brought people in from other states. The Senate is exploring whether the State should use some unspent administrative dollars – \$52 million – to support a grant program for child and youth crisis services.

Another Commission project is to look at the issue resolution process. A subcommittee held a meeting with a group of advisors. DHCS reported that every county under the performance contract must have an issue resolution process; DHCS has an oversight role.

DHCS reported very low usage of the issue resolution process. The Commission recognizes that something is not right.

The Commission has two expansive projects underway.

- It is formulating the design of the intersection of the mental health system and the criminal justice system. It will focus on adults and opportunities to reduce criminal justice involvement, as well as improving the quality of care for people who are criminal justice-involved. It is led by Sheriff Brown from Santa Barbara County.
- It is putting together a proposal for the intersection of the mental health system and the schools, with a focus on children aged 0-8 or 0-10. It is led by Sacramento Superintendent of Schools Dave Gordon.

The first public hearings for both of the topics will probably be in late summer. The Commission will probably do two or three full Commission meetings, as well as site visits, Advisory Committee meetings, and possibly community forums.

The Triage program is underway with 24 counties participating. The Commission has learned a lot about implementation and now is shifting to county sharing of lessons learned.

Regarding Innovation, the Commission has a Budget Change Plan to ask the Legislature for funds to hire three additional staff to build a five-person innovation team. The team will help the State think strategically about innovation; support the ability of the counties to think about shared challenges; fortify Commission ability to do technical assistance, and research and evaluation; and disseminate information.

The Commission has submitted a proposal to the Legislature to expand resources for advocacy on behalf of the LGBTQ community. All dollars would be run through a competitive RFP process. The RFP will probably go public within the next two weeks.

The Commission is working with each of its committees to be more strategic in deployment of their time and talents.

The Commission is thinking about its role in terms of data and analytics. The State is trying to move quickly to get better at data sharing across agencies.

The Commission needs to look at plan review and how it supports the ability of advocates to understand what is in place in their counties, and how that compares to their needs so that they can engage the community planning process in terms of their priorities. The Commission wants to fortify the community planning process.

### **Questions and Discussion**

Mr. Shwe expressed appreciation that the Commission is working on the issue resolution process; it is very important from a consumer perspective. Mr. Ewing commented that some counties feel that it should not be a priority because it is not broken, but the Commission feels that it is indeed broken.

Ms. Prettyman, who had sat on the MHSOAC committee, said that we have a grievance process for one part of services and an issue resolution process for a different part of services. She felt it would be best to bring the two together. She also felt that poor dissemination of the information about the issue resolution process and the grievance process is a huge problem.

Ms. Prettyman urged the MHSOAC to include consumers and family members in all that they do, to obtain their perspective. Last, she was very pleased to see the community forums continuing. She noted that information obtained from consumers and family members did not always come out in the reports. Mr. Ewing pointed out that four of the Commissioners are consumers and family members; currently there are two vacancies.

Ms. Treadwell referred to the project on crisis services: where can the CMHPC be connected? Mr. Ewing replied that this is more about mental health services and there is discussion about a licensing facility. The project is fairly far along and the MHSOAC could have engaged the Department of Social Services better. The full draft report for the

subcommittee will be discussed in an open public forum, before it goes to the full Commission.

Ms. Tucker asked for a list of committees that are for consumers and family members. Mr. Ewing replied that consumers and family members hold seats on the Commission, and they hold seats on all of the project advisory committees and the Evaluation Advisory Committee. Mr. Ewing explained the MHSOAC committee structure. He stressed that everything the MHSOAC does is heavily informed by persons with lived experience and their family members and supporters – that is required by the MHSA, and that is how we transform the system.

Ms. Tucker asked about the focus on adults within the criminal justice system: are there plans to focus on the TAY population later? Mr. Ewing responded that Sheriff Brown works with adults, so that has been his focus. We will bring additional topics back to the Commission on a rolling basis.

Ms. Prettyman commented that consumers and family members can be a great help in reading Plan Reviews, noticing things that staff members do not notice. Mr. Ewing responded that when entities are used to help define quality, it allows many people to use that standard to pass judgment on something – a classic example is vehicle reviews. If we really want to empower the broader public to engage in the Plan Reviews, we need to make it easier to translate what quality looks like. Can we develop a certification standard that allows anyone to assess whether the priorities in the local plan fit the local community? (An example is crisis services.)

Mr. Ewing stressed that the more we can expand the circle of people who are engaged – local boards, local mental health organizations, NAMI affiliates – the better the quality.

Mr. Leoni pointed out the importance of information-sharing between the CMHPC and the MHSOAC. He also pointed out that the Client and Family Leadership Committee and the Cultural and Linguistic Competence Committee are headed by Commissioners who are consumers. Both committees are moving in a direction of more openness and interaction with the public. Last, Mr. Leoni noted that the Advisory Workgroup is chaired by a subcommittee of Commissioners, but their meetings have an open format similar to town hall meetings. He urged the Council members to become involved at the MHSOAC.

Mr. Schroeder commented that the issue resolution process problem sounds a lot like the problem the Department of Managed Health Care is having around medical reviews. He hoped that the MHSOAC's work may be useful for them. Mr. Ewing noted that some problems that should be going through the issue resolution process are going elsewhere; they may or may not be better served there. Core issues may be around education and awareness, with additional issues probably around quality of the process. With clarity, consistency, and quality, improvement of the process should see a minimum of conflict with the counties and DHCS.

## **(9.) ADJOURN**

Chair Black adjourned the meeting at 11:43 a.m.

S   TAB SECTION

DATE OF MEETING 6/15/16

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/17/16

<b>AGENDA ITEM:</b>	Approval of 2016 Policy Platform
<b>ENCLOSURES:</b>	Draft 2016 Policy Platform

**BACKGROUND/DESCRIPTION:**

The Legislative Platform has been renamed to be the Policy Platform. The name is changed to better reflect the purpose of the platform in guiding the Council's positions on proposed policy, legislation, regulations and other initiatives. The Policy Platform will be revised and adopted every two years to follow the 2-Year legislative cycle. Revision may occur sooner, if necessary, but at the minimum the platform will be revisited and approved every two years.

The Advocacy Committee has revised the attached Policy Platform and is bringing it forward for full Council approval for the year 2016 which is the second year of the 2015-16 legislative cycle. It is anticipated that a new Policy Platform will be brought forward in January 2017.

# CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

## POLICY PLATFORM

January 2016 - Revised

The California Mental Health Planning Council has federal and state mandates/duties to review State Plans, advocate for individuals with serious mental illness, children with severe emotional disturbance and other individuals with mental illnesses or emotional problems and to monitor the mental health services within the State.

The statements below are the Council's guiding principles.

1. Support proposals that embody the principles of the *Mental Health Master Plan*.
2. Support policies that reduce and eliminate stigma and discrimination.
3. Support proposals that address the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members.
4. Support proposals that augment mental health funding, consistent with the principles of least restrictive care and adequate access, and oppose any cuts.
5. Support legislation that safeguards mental health insurance parity and ensures quality mental health services in health care reform
6. Support expanding affordable housing and affordable supportive housing.
7. Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on SSI.
8. Support expanding employment options for people with psychiatric disabilities, particularly processes that lead to certification and more professional status and establish stable career paths.
9. Support proposals to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
10. Support initiatives that reduce the use of seclusion and restraint.
11. Support adequate funding for evaluation of mental health services.
12. Support initiatives that maintain or improve access to mental health services, particularly to unserved, underserved populations, and maintain or improve quality of services.
13. Oppose bills related to "NIMBYism" and restrictions on housing and siting facilities for providing mental health services.
14. Support initiatives that provide comprehensive health care and improved quality of life for people living with mental illness, and oppose any elimination of health benefits for low income beneficiaries, and advocate for reinstatement of benefits that have been eliminated.
15. Oppose legislation that adversely affects the principles and practices of the Mental Health Services Act.
16. Support policy that enhances the quality of the stakeholder process, improves the participation of consumers and family members, and fully represents the racial/cultural demography of the targeted population.

17. Support policies that require the coordination of data and evaluation processes at all levels of mental health services.
18. Support policies that promote appropriate services to be delivered in the least restrictive setting possible.
19. Support policies or legislation that promote the mission, training and resources for local behavioral health boards and commissions.
20. Support policies/initiatives that promote the integration of mental health, substance use disorders and physical health care services.

The policies below are issues of interest to the Council.

1. Support proposals that advocate for blended funding for programs serving clients with co-occurring disorders that include mental illness.
2. Support proposals that advocate for providing more services in the criminal and juvenile justice systems for persons with serious mental illnesses and/or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.
3. Support proposals that specify or ensure that the mental health services provided to AB109 populations are paid for with AB 109 funding.
4. Support the modification or expansion of curricula for non-mental health professionals to acquire competency in understanding basic mental health issues and perspectives of direct consumers and family members.
5. Promote the definition of outreach to mean “patient, persistent, and non-threatening contact” when used in context of engaging hard to reach populations.
6. Support policies, legislation or statewide initiatives that ensure the integrity of processes at the local behavioral health boards and commissions.
7. Support the modification or expansion of curricula for Mental Health professionals to fully encompass the concepts of recovery, resiliency, cultural competence, cultural humility, and perspectives of consumers, family members and members of cultural communities.

I   TAB SECTION

DATE OF MEETING 6/15/16

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/16/16

<b>AGENDA ITEM:</b>	Recovery Lifestyles, a SUD Treatment Program at Patton State Hospital
<b>ENCLOSURES:</b>	Overview of Patton State Hospital

**BACKGROUND/DESCRIPTION:**

Dr. Troy Freimuth, PsyD, specializes in clinical psychology and is the Director of Substance Abuse at Patton State Hospital.

The Planning Council has oversight authority of not only the community mental health system but also of the state hospital system in California. While the Council is learning about substance use treatment in the community, it is also important to understand the services provided within the state hospital setting as well. Due to the connections of one of our members, Maya Petties, we are able to talk with Dr. Freimuth while we are meeting in close proximity to Patton State Hospital.

Below is an excerpt from the Dept. of State Hospitals Newsletter, written in the early days of the program's development. Attached is more information regarding Recovery Lifestyles Program and Patton State Hospital.

**Change isn't easy, but DSH-Patton's drug treatment program paves the way**

The old joke is it only takes one psychologist to change a light bulb – but the light bulb has to want to change.

Then again, motivation doesn't always have an on-off switch. Re-searchers say it's more complex than that. They've identified a series of stages most of us go through on the way to change, including contemplation, preparation, action and maintenance.

So how do DSH-Patton clinicians get patients who've abused drugs to want change?

They meet them where they're at.

The hospital's up-and-coming Recovery Lifestyle Program (RLP) matches treatment to a patient's willingness to seek help.

—We help patients bring out their own concerns about drug use, creating a safe environment where they don't feel pressured. When patients feel safe it frees them up to the possibility of change, said Dr. Troy Freimuth, DSH-Patton's substance abuse treatment director.

For patients who are unsure if they have a drug problem there's a one-week class called —Awareness. This program gives them an opportunity to ask questions and be introduced to treatment providers.

At the earlier stages of change clinicians also use motivational interviewing, an empathetic counseling style which supports patients in their desire to be healthy.

There's a mid-stage program which serves as a mini intro to the hospital's more intensive treatment.

And the goal of it all is to get patients into a rigorous 18-week program which incorporates cutting edge, research based treatment with elements of cognitive behavioral therapy, mindfulness and 12-step.

—Just like the name suggests, the Recovery Lifestyle Program is really a lifestyle change in the way patients think, feel and respond to situations, said Dr. Freimuth.

RLP, which was started last year, currently provides treatment to about 150 mentally disordered offenders and defendants found not guilty by reason of insanity.

But Freimuth hopes to make it available to all of DSH-Patton's 1,500 patients – over 90 percent of who have some history of substance abuse. For that to happen he needs resources, and most importantly, clinicians.

The expansion won't happen overnight. But that's OK, because as Freimuth knows all too well – neither does change.

## **DSH-Patton – Substance Recovery Services**

The Recovery Lifestyle Program (RLP) is Patton's hospital wide, substance recovery treatment program. RLP is currently providing treatment to around 230 patients in various stages of change.

In addition, Patton has a hospital wide, AA/NA peer support program, and many units have their own, non RLP related, substance recovery groups. Between the AA/NA program and unit based treatment, an additional 250 patients are being served.

Total number of patients who are enrolled in substance recovery treatment at Patton: **480**

### **RLP is Divided into 3 Interrelated Programs.**

1. “Outreach”/Early stage treatment: a variety of groups in each patient compound cofacilitated by unit staff. designed to be *accessible*, to *engage*/"reach out," and to *“meet patients where they are at.”*
  - A. Awareness
  - B. Group motivational interviewing (MI) and Creative Arts MI
  - C. 12 step Preparation/Facilitation
  - D. Open Recovery
2. Intensive treatment program: Six month centralized program, 3 full days per week.
  - A. SKILLS: For cognitively and/or psychiatrically challenged patients
  - B. PRINCIPLES: For patients with less cognitive and psychiatric interference for learning.
3. Aftercare/maintenance program: 6 month program (minimum) of 1-2 groups per week. Designed to individualize and generalize skills.

**RLP Staffing – 7 (5 PT's, 1 RN, and 1 Psychologist/Director)**

1/24/15

### **Staffing “Partnership Program”**

*(Staff who provide some assistance to RLP staff but who are not “assigned” to substance recovery services at Patton)*

1. “Affiliated providers:” A small but dedicated group of unit assigned clinicians and nursing staff trained by RLP staff to provide/coprovide one or more RLP “branded” groups.
2. Patton MI team: (3 psychologists and 1 RT) a team of MI practitioners who promote, provide, train, and monitor MI treatment fidelity at Patton.
3. Integration with the AA/NA volunteer services program: The AA/NA program and RLP have partnered to provide early stage 12 step groups throughout the hospital.

### **Some Key Guiding Principles**

1. Evidence based approach
  - A. Extensive treatment model: Based on emerging research that emphasizes the importance of the total duration of substance recovery treatment.
  - B. Program evaluation: multi tiered approach
    - Patient “Satisfaction Surveys”
    - Interviews of staff and patients
    - Outcomes evaluation/research: in conjunction with Shannon Bader, Ph.D. and Sean Evans, Ph.D.
2. Integrated treatment approach: utilizing the strengths of various approaches, MI, CBT, 12 step/spirituality, and mindfulness.
3. Tailored for different populations: commitment types, stage of change, cognitive, and psychiatric functioning
4. Close integration and communication with unit treatment teams
5. Individualized/”Strengths based”/motivational approach
6. “Cross Pollination”: Partnering and cross training with unit clinicians, trainees, other Patton programs, and other DSH hospitals

## **Future Goals**

1. “After the Aftercare program”: utilizing peer leaders to provide mentoring/sponsorship/peer facilitated groups
2. Hold campus wide “Recovery” events and create a “Recovery” center
3. Environmental and institutional interventions: work with administrative staff to devise structural and environmental prompting to help patients make positive treatment choices.
4. Increase staffing resources
5. Utilize MI experts hospital wide: Creation of an MI “SWAT team” to provide short term motivational therapy for patients who are found to be selling or misusing substances. (eventually expanding into “high risk” medical refusers and other adherence/treatment areas)

## Department of State Hospitals - Patton

### HISTORY

The Department of State Hospitals-Patton is a forensic psychiatric hospital located in Patton, CA, in San Bernardino County. DSH-Patton was established in 1890 and opened in 1893. DSH-Patton provides treatment to forensically and civilly committed patients within a secure treatment area. The hospital does not accept voluntary admissions.

### PATIENT POPULATION

The hospital currently operates 1,527 beds. The four primary commitment categories of patients treated at DSH-Patton are described below:

#### ***Incompetent to Stand Trial (PC 1370)***

Felony and misdemeanor defendants found incompetent by a court are placed in a state hospital where the focus of treatment is to help them regain trial competency and return them to court so they may be adjudicated on their pending charges. Those patients who are unable to be restored to competency within a three (3) year time period are returned to the court to determine future status and may be recommitted civilly pursuant to WIC 5008, as a Murphy Conservatee.

#### ***Mentally Disordered Offenders (Penal Code Section 2962/2972)***

Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term. If the person still requires treatment at the end of their parole term, they may be civilly committed under PC2972 if it is determined that they are a substantial danger to others. These commitments last for one year and may be renewed annually by the court. The focus of treatment for this population involves helping the patient increase their ability to safely and effectively manage the symptoms associated with their mental illness.

#### ***Not Guilty by Reason of Insanity (PC 1026)***

Persons judged by the court to be guilty of a crime, but not guilty because they were insane at the time of the crime are committed to a state hospital for treatment for a period equal to the maximum sentence for their most serious offense, subordinate offenses and enhancements. The ultimate goal is for the patient to reintegrate into the community with an increased awareness of their role within society and to take responsibility for personal and public safety. The focus of treatment for this population involves helping the patient development insight into their mental illness and how the symptoms of mental illness led to the commission of a crime. Further, the patient must also demonstrate the ability to safely and effectively manage the symptoms associated with their mental illness.

### **Conservatees (LPS & Murphy)**

LPS Conservatees under Welfare and Institutions Code (WIC) 5008(h)(1)(A) may be placed at DSH-Patton after it has been determined that they exceed the admission criteria for either DSH-Metropolitan or DSH-Napa, and the Conservator has ordered placement at DSH-Patton. For the LPS population, the focus of treatment involves helping patients develop basic life skills to enhance their overall quality of life such that they can function optimally in a lower level of care (e.g. IMD or Board and Care). For Murphy Conservatees, under Welfare and Institutions Code (WIC) 5008(h)(1)(B) and WIC 5358, the focus of treatment for this population remains restoration of competency.

The primary patient population breakdown for DSH-Patton is listed below:

<b>Patient Category</b>	<b>Percentage</b>
Incompetent to Stand Trial (PC 1370)	36%
Mentally Disordered Offenders (PC 2962/2964a & 2972)	19%
Not Guilty by Reason of Insanity (PC 1026)	38%
Conservatees (LPS and Murphy)	7%

### HOSPITAL STAFF

Approximately 2,700 employees work at DSH-Patton providing around-the-clock care, including psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians and other clinical and administrative staff. There are approximately 349 different job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other clinical and administrative staff.

### TREATMENT AND PROGRAMS

The Trial Competency Program is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial. These patients receive a specialized program of treatment which is designed to specifically help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense.

The focus of treatment for our Mentally Disordered Offender (MDO) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to enhance the quality of the patient's life at the hospital and prepare them for eventual transfer to Community Outpatient Treatment

(C.O.T.). Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of Activities of Daily Living (ADL) skills and self-discipline.

All treatment programs at DSH-Patton utilize the recovery philosophy offering a broad spectrum of treatment, while fully endorsing the hospital's mission to provide comprehensive clinical services within the context of a biopsychosocial rehabilitation model within an environment of safety and security for all patients, staff and the community in an atmosphere of dignity and respect

U   TAB SECTION

DATE OF MEETING 6/15/16

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/14/16

<b>AGENDA ITEM:</b>	Overview of California's Child Welfare Continuum of Care Reform
<b>ENCLOSURES:</b>	California's Child Welfare Continuum of Care Reform Report

**BACKGROUND/DESCRIPTION:**

Cheryl Treadwell is the Planning Council member from the California Department of Social Services. She is the Chief of the Foster Care Rates and Audits Branch. Last year, Cheryl shared the legislative report listed above (web link below).

Cheryl will provide an overview of the Child Welfare Continuum of Care Reform actions. Below is some background information of events that led up to the Child Welfare Services Realignment and Reform.

In response to the need for changes to the Foster Care system to ensure more positive outcomes for the children, youth and families, in June 2012, Budget Trailer Bill language was passed under SB 1013, Child Welfare Services Realignment.

The 2011-12 Budget realigned \$1.6 billion in state funding for the Child Welfare Services (CWS), foster care, and adoptions programs, to the counties. For the first year of the 2011 realignment, no changes were made to state law governing CWS and adoptions programs. During the 2012-13 budget process, however, the Administration proposed programmatic trailer bill language related to the following major themes, all of which are addressed by this trailer bill:

1. Flexibilities for Counties
2. Accountability and Oversight
3. Continuum of Care and Needs Assessment-Related Reform
4. Repeals of Sunsets and Change to Make Specified Programs Statewide
5. Technical Changes.

The CWS system includes child abuse prevention, emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care. Existing law also establishes the California Child and Family Service Review System administered by Department of Social Services (DSS) to review all county child welfare systems.

[Link to California's Child Welfare Continuum of Care Reform Report](#)

Additional overview information

Most children are placed in Child Welfare Services (previously known as foster care) pursuant to a court order. A risk assessment of abuse and/or neglect and a strengths/needs assessment are conducted at critical points such as entry, change in status and exit. Each child in Child Welfare must have a case plan. Mental health services are included in the case plan, when needed. The case plan is written by the county social worker in collaboration with the family members of the child. The plan is modified along the way and the social worker is responsible to ensure the plan is followed and for connecting/referring the foster parents to any services identified in the case plan.

Child Welfare is a complex system and each county designs its services to meet the unique needs of its community. Some counties are able to have one social worker for the child from beginning to end while other counties have different social workers for different phases of the system that the child may go through. So oversight of the child's needs differs between the counties.

Phases could include emergency response, court, family reunification, long-term care, adoptions, legal guardianship, and independent living.

Disclaimer: The above is provided to give some basic foundational information and is an extremely simplified overview of a very complicated and varied system. Additionally, other segments of Child Welfare, such as Adoptions, will not be addressed during this meeting.

V   TAB SECTION

DATE OF MEETING 6/15/16

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/16/16

<b>AGENDA ITEM:</b>	Panel re: Mental Health Services to Children in Foster Care including under the Katie A. Court Order
<b>ENCLOSURES:</b>	Overview of Court Appointed Special Advocates for Children, San Bernardino County

**BACKGROUND/DESCRIPTION:**

The Council is commencing the new theme for the fiscal year; children and youth.

Many of the individuals served in the public mental health system also are/have been involved with other systems such as foster care, criminal/juvenile justice, and special education. These multi-system users are very costly not only in dollars but in lives. When it is children who are multi-system involved, most likely they are not on a positive path for success in their adulthood. In many ways, when an individual is involved in multiple systems, we have failed him/her. At this June meeting, we are delving into the child welfare foster care system.

The Council will hear from a panel that includes Court Appointed Special Advocates (CASA) from San Bernardino and Riverside counties, Foster Care Ombudsman from San Bernardino County, and current/former Foster Parents of children with mental health needs from San Bernardino and Riverside counties.

## **What are Katie A Services and Why Are They Critical to Foster Care Youth?<sup>1,2</sup>**

**This summary describes the history and settlement agreement of the “Katie A.” lawsuit. The outcome mandates that the health and safety of youth with serious mental health needs must be treated as an absolute priority. Here’s the story.**

### **KATIE’S STORY:**

With her mother homeless and father incarcerated, four-year-old Katie A. entered California’s foster care system. By age five, Katie’s assessments indicated she was a victim of trauma and in need of treatment. Despite pleas to child welfare, Katie never received the mental health treatment she needed. Instead, she was shuffled through an astonishing 37 placements in 10 years, including psychiatric facilities and group homes. This instability and lack of adequate mental health treatment was devastating.

Katie’s story is not so unusual. Children who are abused, neglected and removed from their families disproportionately suffer mental health disorders. Youth living with foster parents or in group homes have about four times the rate of serious mental health needs as young people living with their own families. Children with the greatest mental health needs often receive inadequate mental health support. Roughly 3 out of 5 children in out-of-home care have moderate to severe mental health issues, but fewer than 1 in 3 receive any mental health treatment at all.

### **THE LAW and the Katie A Court Settlement:**

System-wide deficiencies are not only harmful to children like Katie – they are against the law. Under federal law, states MUST provide children and youth a broad array of mental health services and supports, including treatments based in a child’s home and community, not in a facility or group home. If more children receive intensive mental health treatment in their homes before behaviors escalate beyond their families’ ability to cope, fewer children will enter foster care. Filed in 2002, the *Katie A. v. Bonta* lawsuit sought to enforce the law and fix the youth mental health system.

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<sup>1</sup> Information in this document taken from the Fact Sheet: [Fulfilling Medi-Cal’s Promise: What are Kate A. Serives and Why are They Critical?](#) From the website: [www.youngmindsadvocacy.org](http://www.youngmindsadvocacy.org), February 2016.

<sup>2</sup>California Department of Health Care Services (DHCS) website for the “Katie A” Settlement Implementation, at <http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx>.

Specifically, the plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California.

On December 2, 2011, Federal District Court Judge A. Howard Matz issued an order approving a proposed settlement of the case. The settlement agreement seeks to accomplish systemic change for mental health services to children and youth within the class by promoting, adopting, and endorsing three new service array approaches for existing Medicaid covered services.

Katie A. Subclass members are a class of children in the *Katie A. v. Bonta* lawsuit and are defined in the Settlement Agreement. Eligible children and youth are those who are full-scope Medi-Cal, meet medical necessity for treatment, have an open child welfare services case, and must meet either of the following criteria:<sup>3</sup>

- Currently in or being considered for: Wraparound, therapeutic foster care or other intensive services, therapeutic behavioral services, specialized care rate due to behavioral health needs or crisis stabilization or intervention; or
- Currently in or being considered for a group home, a psychiatric hospital or 24-hour mental health treatment facility, or has experienced his/her 3<sup>rd</sup> or more placement within 24 months due to behavioral health needs.

The California Department of Social Services (CDSS) and Department of Health Care Services (DHCS) have been working with the federal court appointed Special Master, the plaintiffs' counsel, and other stakeholders to develop and implement a plan to accomplish the terms of the settlement agreement.

The implementation plan for DHCS and CDSS includes their new [Medi-Cal Manual for Intensive Care Coordination \(ICC\), Intensive Home Based Services \(IHBS\) & Therapeutic Foster Care \(TFC\) for Katie A. Subclass Members](#).<sup>4</sup> It gives mental health plans (MHPs) and others information about the provision of intensive services to children/youth who are members of the Katie A. Subclass and their families. There is a companion document,<sup>5</sup> "[Pathways to Mental Health Services - Core Practice Model Guide](#)

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<sup>3</sup> Katie A. VS. Bonta: Mental Health Services for Foster Children. CalSWEC (2011). Posted at: [https://www.csuchico.edu/swrk/mh/docs/Katie\\_A\\_Overview.doc](https://www.csuchico.edu/swrk/mh/docs/Katie_A_Overview.doc).

<sup>4</sup> [Medi-Cal Manual for Intensive Care Coordination \(ICC\), Intensive Home Based Services \(IHBS\) & Therapeutic Foster Care \(TFC\) for Katie A. Subclass Members](#)., [http://www.dhcs.ca.gov/services/MH/Documents/ICC\\_IHBS\\_TFC\\_manual.pdf](http://www.dhcs.ca.gov/services/MH/Documents/ICC_IHBS_TFC_manual.pdf)

<sup>5</sup> [Pathways to Mental Health Services - Core Practice Model \(CPM\) Guide](#). <http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf>

[\(CPM\) Guide](#)” ([Text Version](#)), which describes how individual service providers and systems should address the needs of children/youth and families in the child welfare system to promote permanency, safety, and mental well-being.

As a result, new, more intensive services are available, and collaboration between California’s child welfare and mental health systems has improved. Child and Family Teams are more readily available, where young people, their caregivers, and their treatment team work together to set goals and plan care. More recently, other Medi-Cal eligible children and youth who are not members of the “Katie A.” subclass have also achieved the right to access these services if there is a medical necessity. When fully realized, as many as 35,000 California youth may receive intensive mental health services in their own homes and communities each year. Thus, there is great need for more mental health practitioners and caregivers to meet all the expected demands.

## **WHAT ARE THE “KATIE A.” SERVICES?**

“*Katie A.* services” include Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC). These services are provided in a young person’s home or school or recreation center so that they don’t have to grow up isolated, in far-away facilities. And, young people and their families help create the treatment plan based on *their* own needs, strengths, and goals. Serving youth with intensive mental health needs in this way means better life outcomes – better school performance, less involvement with police and the courts, more satisfying relationships – and less disruption, a fact affirmed by research and practice nationwide.

## **A CLOSER LOOK: *What are ICC, IHBS & TFC?***

### **Intensive Care Coordination (ICC):**

- Creates a Child and Family Team (CFT) made up of a child’s formal (care coordinator, providers, case managers) and natural supports (family, neighbors, mentors).
- Together, the CFT employs a treatment plan of individualized services that celebrates the strengths and goals of the youth and family.
- The young person’s health care providers and support network work together to provide effective services in home and community settings.

### **Intensive Home Based Services (IHBS):**

- Encourages the Child and Family Team to help the youth build and maintain skills needed to thrive.
- Treatment interventions are highly individualized, evidence-based wherever possible, and not arbitrarily limited in how long or often they may be used.

- Includes strength-based services and supports to address mental health-related issues that may harm the child’s development and wellbeing.
- Educates young people and their families about the youth’s mental health challenges and how to manage them together as a team.

**Therapeutic Foster Care (TFC):**

- Intensive, individualized mental health services are “wrapped around” the youth in the therapeutic foster home.
- Foster parents are given specialized training and access to a diverse support network.
- Generally, only one or two youth reside in a therapeutic foster home to allow for greater care and oversight.

**HOW MANY FOSTER YOUTH ARE NOW RECEIVING “KATIE A” SERVICES AND OTHER SPECIALTY MENTAL HEALTH SERVICES<sup>6</sup>?**

Total Numbers of California Foster Youth Receiving “Katie A” and other Mental Health Services in fiscal years 2014 or 2015 (DHCS data updated 3/29/2016):

Statewide: Certified Medi-Cal eligible Foster Care Youth FY 2013-2014: **77,405**.

- Total Number of Medi-Cal Youth ages 0-20 who received at least one Specialty MH Service during FY 2013-2014: **34,353** (penetration rate 44.3 %).
- All Medi-Cal Eligible Foster Care Youth who received five or more Specialty MH Service during FY 2013-2014: **26,692**.

Statewide, (FY 2014-2015) Total Unique Katie A Subclass Members: **14,927**

- Members who received IHBS: **7,466**
- Those who received ICC: **9,667**
- Those who received Case Management/Brokerage: **9,077**
- Received Crisis Intervention Services: **523**
- Received Medication Support Services: **3,293**
- Received Mental Health Services: **12,435**
- Received Day Rehabilitation: **285**
- Received Day Treatment Intensive service: **63**
- Received Hospital Inpatient treatment: **19**
- Received Psychiatric Health Facility treatment: **41**
- Therapeutic Foster Care: Data not yet available at DHCS website.

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<sup>6</sup> Data reports are from: <http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx>

# Foster Care Highlights from Child Welfare Council Reports, 2013-2016<sup>1,2</sup>

## Permanency and Re-unification<sup>1,3</sup>

While there is a lot of good news in child welfare – for example, the number of California children in foster care has been reduced by 46% since 1998. But there is bad news too – for example, the number of youth in foster care who turn 18 without a permanent family has remained constant at about 4,000 every year.

A major priority is to provide services to support family reunification, which means returning a child who has been placed in foster care to safe care by their parents. Nationally, only about half of families in the child welfare system succeed in reunification. In California 26% of families with a child in foster care have their child returned home within 6 months; about 43% within one year; and 62% within 2 years. But about 10 % of children who have been reunified return to foster care due to subsequent instances of child abuse and neglect within 12 months.

## Young Children in Foster Care

The Child Welfare Council's Child Development and Successful Youth Transitions Committee formed a Young Children in Foster Care Work Group. This group partnered with First 5 California to add information to assist foster parents and others caring for young children to the First 5 website at: <http://www.first5california.com/parents/services-support.aspx?id=26>.

The website's introductory message reads:

Young children involved with child welfare have faced challenges in their young lives and need extra support so they can heal. Early childhood experiences can affect children's development and have a lasting effect on their lives. Infants and toddlers in child welfare are especially vulnerable. Relationships are critical to set them on a path for healthy development and brighter outcomes. For additional information on early childhood adversity and child welfare, links are provided to access:

- Information about what trauma is, how it affects children, and recommendations for serving children who are exposed to complex or traumatic stress.
- Quick facts on young children in foster care.
- Information regarding the special care infants and toddlers in foster care require to develop their full potential; all partners who work with them have a role.
- Videos and further knowledge on the impact maltreatment can have on the developing brain.
- One of the largest online sources for issues addressing child welfare, the families and children they serve.

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<sup>1</sup> Prioritization Task Force Final Report, California Child Welfare Council, June 2013

<sup>2</sup> California Child Welfare Council 2014-2015 Annual Report, July 2015, [www.chhs.ca.gov/Pages/GeneralInformation.aspx](http://www.chhs.ca.gov/Pages/GeneralInformation.aspx).

<sup>3</sup> Needell, B., Webster, D., Arijo, M., et al. (2012) Child Welfare Services Reports for California. Retrieved from: [http://cssr.berkeley.edu/ucb\\_childwelfare](http://cssr.berkeley.edu/ucb_childwelfare) .

## Out of County Mental Health Services

The Child Welfare Council continues to monitor the Department of Health Care Services' (DHCS) progress toward the goal of improving access to timely and effective mental health services for all foster children placed outside their county of jurisdiction. DHCS's Behavioral Health Division is seeking commitments from the County Behavioral Health Directors Association, County Welfare Directors Association of California, and CDSS on the following components of a proposed policy:

- Screening and Assessment.
- Authorization of Services, which has a child and family focus and alignment with permanency goals.
- Services (Continuum of Care Reform and Treatment Foster Care).
- Payment and Financing.
- Capacity and Accountability.

The proposed policy seeks to account for recent programmatic and fiscal changes impacting the child welfare, probation and mental health programs. The policy also considers the child's best interests for safety, permanency and well-being and recent program/fiscal changes including the Katie A Court Settlement and Core Practice Model; the Continuum of Care Report Recommendations; and 2011 Realignment.

## Psychotropic Medications

The Child Welfare Council's Child Development and Successful Youth Transitions Committee formed a work group to give feedback and follow the progress of the state's Quality Improvement Project (QIP), which was addressing the issue of foster children's use of psychotropic medications. The work group wanted to bring attention to the seriousness of the problem and urgency for solutions, referring data that showed too many children are being prescribed too many drugs, for too long a period of time, and for purposes that do not align with the intended purpose of the drug.

The work group presented the following data to illustrate the problem:

- 8,080 foster children 0-17 filled a prescription for Psychotropic Medication

Of foster children prescribed psych meds:

- 51% given antipsychotics
- 48% given antidepressants
- 32% given stimulants
- More than 30% of children prescribed psych meds are given multiple medications long term
- 354 foster children were on 2 meds in the same class long term.

Top Diagnoses 2012-13 were as follows (Note the potential for misdiagnosing trauma and the frequency of off-label prescribing):

- ADD/ADHD (3, 548 claims)
- Mood Disorders (3, 336 claims)
- Adjustment Reaction (2,425 claims)
- Disturbance of Conduct, NEC (1,630 claims)
- Disturbance of Emotion (1,341).

## The Invisible Achievement Gap – Education Outcomes of Students in Foster Care in California’s Public Schools

Success in school and achieving good educational outcomes can contribute to the overall mental health and well-being of children generally. But mastery of these goals is particularly important to prepare foster care youth for their eventual successful transition to independent living and adulthood. Thus, it is important to understand the factors affecting the educational outcomes of foster children in school, including for example, the presence of disabilities and the frequency of school transfers as the child is moved from one foster home to another. Such disruptions are damaging to the formal and informal emotional supports and attachments foster children have in the school environment and may handicap one’s educational outcomes.

The serious nature of the problem is illustrated by a Chapin Hall report (2015) based on a national survey of youth in foster care:

- 90% of youth reported that they had to change schools because of foster care placement change or family move. About a third of these changed schools seven or more times.
- 33% of youth reported being out of school for one month or more because of a foster care placement change.
- 66.7% reported being suspended from school and 27.7 % had been expelled.
- 33.5% of youth had repeated a grade.

The effects of these and other factors on California foster youth were investigated in a study sponsored by the Stuart Foundation (2014). This study was conducted under the auspices of the Center for the Future of Learning at WestEd in partnership with the University of California’s Center for Social Services Research, the California Department of Education, and the California Department of Social Services.<sup>4</sup>

The key findings for California foster youth included:

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<sup>4</sup> Wiegmann, W., Putnam-Hornstein, E., Barrat, V. X., Magruder, J. & Needell, B. (2014). The Invisible Achievement Gap, Part 2: How the Foster Care Experiences of California Public School Students Are Associated with Their Education Outcomes. <http://www.stuartfoundation.org/docs/default-document-library/IAGpart2.pdf?sfvrsn=4>.

- **Time in Foster Care** – More than 43,000 (or about one of every 150 K-12) public-school students in California spent some period of time in child welfare supervised foster care.
- **Reason for Removal** – Of students in foster care, 78% were removed from birth families due to neglect, 11% physical abuse; 4% sexual abuse; and 7% other reasons.
- **Grade Levels** – Of these students in foster care, 40% were in Elementary School; 23% were in Middle School; and 36% were in High School.
- **An At-risk Subgroup** – Nearly one in five students in foster care had a disability compared to 7% of all K-12 students and 8% low socioeconomic status (SES) students.
- **School Mobility** – Among students who had been in foster care for less than one year, 48% had changed schools during the academic year.
- **School Type** – Enrollment in a nontraditional school often suggests that students were unsuccessful in a traditional school setting and therefore were transferred to an alternative setting with the goal to better meet the students' needs.
- **Achievement Gap** – Proficiency in English language arts for students in foster care was negatively correlated with grade level.
- **Drop-out and Graduation** – Students with three or more placements were more than twice as likely to drop out as students with one placement, although this single-year dropout rate is still twice as high as that for low SES students and for K-12 students.

**Conclusions** from the study are that students in foster care constitute an at-risk subgroup that is distinct from low socioeconomic status students regardless of the characteristics of their foster care experience.

Yet, despite relative disadvantage overall, significant variations among students in foster care still emerged. Findings should not be interpreted causally, but still provide information for policymakers and administrators that may help improve the academic success of students in foster care. The complete study results may be found at:

<http://www.stuartfoundation.org/docs/default-document-library/IAGpart2.pdf?sfvrsn=4>.

California's recent landmark legislation, the Local Control Funding Formula (LCFF), marks the first time any state has included foster youth in its school funding and accountability system. It focuses much needed attention on the education outcomes of foster youth. The LCFF not only brings the poor education outcomes of foster youth to the fore, it also spotlights the opportunity for our schools to better serve students in foster care. Early implementation of LCFF has shown some significant advances for foster youth in some districts that devoted increased resources, including staff, to meeting the educational needs of students in foster care.

# Court Appointed Special Advocates for Children, San Bernardino County

## About

The Mission of C.A.S.A of San Bernardino:

To improve the quality of life for foster youth and juvenile offenders with stable and consistent advocacy and mentoring provided through trained community volunteers.

In San Bernardino County, approximately more than 3,400 children live in foster care. Those children were not only abused and/or neglected but as a result, removed from their homes and families. Sadly, many also become victims again in an overwhelmed child welfare system that cannot pay close attention to each child's individual needs and wants.

As dependents of the court, these children pass through a court system which leaves them lost, confused and alone.

While in care, children and youth encounter difficulties that prevent them from becoming successful adults. They often face educational challenges, mental health issues and struggle to maintain healthy, consistent relationships.

(Court Appointed Special Advocates) C.A.S.A. of San Bernardino County recruits, screens and trains volunteers to become appointed advocates for children and youth currently living in foster care. The role of the advocate includes:

- Developing a relationship with the child in order to provide effective recommendations to the court
- Communicating and collaborating with other professionals in the child's life
- Committing to serving their child for a minimum of 18 months for 10-15 hours per month

C.A.S.A volunteers provide stability and hope to abused and neglected children by adding a powerful voice in their lives.

A C.A.S.A volunteer can be any adult in the community who is specifically trained and appointed by a juvenile court judge to:

- Establish a strong and stable relationship with a child
- Gather information, write reports, and make recommendations in the best interest of the child
- Advocate to ensure the child receives the appropriate resources that he or she deserves

Across California, thousands of C.A.S.A volunteers build close relationships with and serve as advocates for foster children. In San Bernardino County, with approximately more than 3,400 children living in foster care, the need for a C.A.S.A volunteer is greater than ever. You can be the voice for children who need it the most.

W   TAB SECTION

DATE OF MEETING 6/15/16

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/16/16

<b>AGENDA ITEM:</b>	Panel re: Outcomes and Support for Youth Exiting Foster Care Including Support Under AB 12
<b>ENCLOSURES:</b>	California Youth Transitions to Adulthood Study, Executive Summary  AB 12 Overview  AB 12 Fact Sheet  California Youth Connections Background  Transitional Housing Placement Plus Foster Care Fact Sheet  Transitional Housing Program Plus Fact Sheet

**BACKGROUND/DESCRIPTION:** Outcomes for foster youth, who exit the foster care system at age 18 years, include being homeless, pregnant, unemployed and with few options for success.

Passed in 2010, AB 12 addresses many issues within the Child Welfare Foster Care System including directing California to implement policies under the federal law, Fostering Connections to Success and Increasing Adoptions Act of 2008. This Act revised and expanded federal programs and funding for certain foster and adopted children. This allows states to implement programming and funding to extend certain foster care supports and benefits beyond age 18 and up to age 21 years.

The Council will hear from a panel that includes the AB 12 Coordinator for San Bernardino County, Service Providers to youth served under AB 12 and youth who received benefits under the new programs pursuant to AB 12. Attached are a number of background documents to orient members to the services available for foster youth post-their 18<sup>th</sup> birthday.

## Assembly Bill 12

### California's Fostering Connections to Success Act

#### **Summary**

When California passed Assembly Bill 12, the California Fostering Connections to Success Act, it allowed our state to opt into several provisions of the Federal Fostering connections to Success and Increasing Adoptions Act of 2008. The California Fostering Connections to Success Act was signed into law September 30, 2010 through Assembly Bill (AB) 12 and became effective January 1, 2012. The bill and subsequent legislation allowed foster care, for eligible youth, to extend beyond age 18 up to age 21. Eligible foster youth are designated as "non-minor dependents" (NMDs). This legislation also recognized the importance of family and permanency for youth by extending payment benefits and transitional support services for the Adoption Assistance Program (AAP) and the Kinship Guardianship Assistance Payment (Kin-GAP) Program.

- Adoption Assistance Program (AAP): Recognizing that adoptive parents often experience financial difficulty meeting the special needs of children who formerly were placed in California's foster care system, the State Legislature created the Adoption Assistance Program (AAP) to encourage the adoption of special needs children and remove the financial disincentives for families to adopt.
- Kinship Guardianship Assistance Payment (Kin-GAP) Program: The Kin-GAP Program became available to those children exiting the juvenile court dependency system on or after January 1, 2000 to live with a relative legal guardian.

#### **Benefits of AB 12**

Some interesting statistics on emancipating foster youth: 50 percent of former foster youth will be homeless during their first two years after exiting foster care, 60 percent of girls become pregnant within a few years after leaving the foster care system, 50 percent of youth leaving foster care are unemployed, and lastly, of all emancipating foster youth, only 3 percent will graduate college.

- Foster youth will be able to maintain a safety net of support while experiencing independence in a secure and supervised living environment.
- Provides youth extended time as “non-minor dependents” to obtain educational and employment training opportunities which assist youth in becoming better prepared for successful transition into adulthood and self-sufficiency.
- It will help youth better prepare for successful transition into adulthood

### **Basic Eligibility Requirements**

At the six month hearing prior to youth turning age 18, the social worker/probation officer must have a plan to ensure the youth meet at least ONE of the following participation criteria:

- 1) Working toward completion of high school or equivalent program (e.g. GED); OR
- 2) Enrolled in college, community college or a vocational education program; OR
- 3) Employed at least 80 hours a month; OR
- 4) Participating in a program designed to assist in gaining employment; OR
- 5) Unable to do one of the above requirements because of a medical or mental health condition. (must be verified by a health practitioner –doesn’t have to be an MD. Health practitioner includes therapists, counselors, physician’s assistants, etc)

Non-minor dependents must sign an agreement to reside in an eligible placement location and agree to work with a social worker/probation officer to meet the goals outlined in their Transitional Independent Living Case Plan.

Youth will automatically remain in foster care after age 18 but it is voluntary. Non-minor dependents can exit at age 18 or at any subsequent time before age 21. Youth who exit at age 18 can re-enter foster care at any time before age 21. In order to reenter, the youth just has to sign a reentry agreement (county also has to sign) and the beginning date of aid is the date that the reentry agreement is signed. The payment for placement is effective the date that the agreement was signed.

Tribal youth under county jurisdiction are also eligible to remain in foster care after age 18.

Tribes with a Title IV-E agreement with the state or federal government can create their own extended foster care (EFC) program.

Probation youth who are in a foster care placement are also eligible for the extended foster care program.

Youth who are custodial parents have the same rights to participate in foster care after age 18 as all other youth.

Youth who are consumers of the Regional Center services can continue to receive dual agency and supplemental rates.

Youth who meet the eligibility requirements to receive SSI (Supplemental Security Income) MAY be eligible to receive both at the same time.

## **Statistics**

Interesting findings of a study (*The Midwest Evaluation of the Adult Functioning of Former Foster Youth*) conducted in the Midwest (Courtney and Dworsky, 2005):

- The study followed 732 youth who exited foster care from Iowa, Illinois, Wisconsin, interviewing them at ages 18, 19, 21, and 24
- The study compared the youth who exited foster care at 18 to youth who stayed longer in care and to a national sample.
- When they followed up with youth at age 19, they found some benefits related to staying in care longer:
  - young adults who had left care were over 50 percent more likely than their peers still in care to be unemployed and out of school;
  - young adults still in care were more than twice as likely to be enrolled in a school or training program as those who had been discharged,
  - young adults still in care who had a high school diploma or GED were over three times as likely as their counterparts who were no longer in care to be enrolled in a 2- or 4-year college.
- At the follow up interviews at ages 21 and 24 (Courtney et al, 2005; Courtney et al, 2007) foster youth were compared to a national sample of same age youth and foster youth did experience more challenges in early adulthood, including:
  - lower income,

- less access to education,
- more health problems,
- more involvement in the criminal justice system. The studies conclude that youth leaving foster care need more support during their transition to adulthood.

A look at AB 12 data in 2014

How many youth age 18-20 are in EFC?

- As of July 1, 2014, 9,032 youth age 18-20 were in foster care in California.
- Of these, 83 percent were child welfare supervised and 17 percent were probation supervised.

How has the number of youth age 18-20 in foster care changed since the implementation of AB12 in California? (California Child Welfare Indicators Project: Youth in Extended Foster Care)

- The number of youth age 18-20 in foster care in California increased 211 percent between July 1, 2010 (2,908) and July 1, 2014 (9,032).
- The number of youth age 18-20 in foster care increased 187 percent among child welfare supervised youth and 418 percent among probation supervised youth.

Exit Trends

The growth in the foster care caseload age 18-20 is attributable to: a decline in exits, and an increase in reentries to foster care, after implementation of AB12.

- Exits from foster care among youth age 18-20 declined 46 percent between 2010 (5,787) and 2014 (3,145).
- Exits declined primarily among youth in child welfare supervised foster care.

Re-Entry Trends

- Following implementation of AB12 in 2012, reentries to foster care among youth age 18-20 have risen each year. In 2012, 300 youth age 18-20 reentered care and in 2013, 553 did so.
- Reentries following implementation of AB12 were most common among youth in child welfare supervised foster care.

What are the demographic and case characteristics of youth in EFC?

- Black and Latino youth account for the majority of 18-20 year olds in EFC.
- Thirty-eight percent of 18-20 year olds in EFC are living in supervised independent living placements (SILP).
- More than half of 18-20 year olds in EFC have been in care for 4 or more years.
- Eighty-one percent of youth age 18-20 receiving services in 2014 were in supportive transition.