



September 29, 2016

To: California Mental Health Planning Council

From: Jane Adcock
Executive Officer

Subject: October 2016 Planning Council Meeting

CHAIRPERSON
Josephine Black

EXECUTIVE OFFICER
Jane Adcock

Enclosed is the packet for the October 19-21, 2016 Planning Council meeting at Lake Natoma Inn in Folsom, CA. The hotel is located at 702 Gold Lake Drive, Folsom, CA 95630. The hotel offers complimentary parking and complimentary meeting room wireless internet access.

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, October 20**, 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 55 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) 322-3807 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

Restaurants near Lake Natoma Inn

702 Gold Lake Dr, Folsom, CA 95630-2559

[Karen's Bakery](#)

705 Gold Lake Dr
0.1 miles from Lake Natoma Inn

[ARZ Lebanese Restaurant](#)

705 Gold Lake Dr Suite 390
0.1 miles from Lake Natoma Inn

[Folsom Bar & Grille](#)

705 Gold Lake Dr
0.1 miles from Lake Natoma Inn

[Snooks Candies & Ice Cream](#)

731 Sutter St
0.1 miles from Lake Natoma Inn

[Q'bole](#)

718 Sutter St Ste 201
0.1 miles from Lake Natoma Inn

[Hop Sing Palace](#)

805 Sutter St
0.1 miles from Lake Natoma Inn

[Pizzeria Classico](#)

702 Sutter St
0.1 miles from Lake Natoma Inn

[Hacienda Del Rio Restaurant](#)

702 Sutter St
0.1 miles from Lake Natoma Inn

[Sutter Street Steakhouse](#)

604 Sutter St
0.2 miles from Lake Natoma Inn

[Sutter Street Grill](#)

811 Sutter St
0.1 miles from Lake Natoma Inn

[Chicago Fire](#)

614 Sutter St Ste A
0.2 miles from Lake Natoma Inn

[Samuel Horne's Tavern](#)

719 Sutter St
0.1 miles from Lake Natoma Inn

[Cellar Wine and Cheese Bar](#)

727 Sutter St # B Historic Folsom District
0.1 miles from Lake Natoma Inn

[Sutter Street Taqueria](#)

727 Sutter St
0.1 miles from Lake Natoma Inn

[Black Rooster](#)

807 Sutter St
0.1 miles from Lake Natoma Inn

[The Fat Rabbit Public House](#)

825 Sutter St
0.2 miles from Lake Natoma Inn

[Powerhouse Pub](#)

614 Sutter Street
0.2 miles from Lake Natoma Inn

[Folsom Hotel](#)

703 Sutter St
0.2 miles from Lake Natoma Inn

[Hampton's On Sutter](#)

608 Sutter St
0.2 miles from Lake Natoma Inn

[Victoria Chocolatier LLC](#)

713 Sutter St
0.1 miles from Lake Natoma Inn

[Sudwerk Riverside Restaurant](#)

9900 Greenback Ln

0.3 miles from Lake Natoma Inn

[Sushi Unlimited](#)

6693 Folsom Auburn Rd

0.5 miles from Lake Natoma Inn

[Pete's Restaurant & Brewhouse](#)

6608 Folsom Auburn Rd

0.5 miles from Lake Natoma Inn

[El Pueblo Cocina Mexicana](#)

6608 Folsom Auburn Rd Suite #1

0.5 miles from Lake Natoma Inn

[Coffee Republic](#)

6610 Folsom Auburn Rd

0.6 miles from Lake Natoma Inn

[Mountain Mike's](#)

1100 Bidwell St

0.5 miles from Lake Natoma Inn

[Scott's Seafood of Folsom](#)

9611 Greenback Ln

0.9 miles from Lake Natoma Inn

[El Pollo Loco](#)

654 E. Folsom Bl

0.5 miles from Lake Natoma Inn

[Bj Cinnamon](#)

402 E Bidwell St

0.7 miles from Lake Natoma Inn

[Taj India](#)

329 E Bidwell St

0.7 miles from Lake Natoma Inn

California Mental Health Planning Council

AGENDA
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
October 19, 20, and 21, 2016
Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630

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

Wednesday, October 19, 2016

COMMITTEE MEETINGS

Time	Event	Room
9:00 a.m.	Executive Committee Meeting	Folsom
11:00 a.m.	Patients' Rights Committee Meeting	Placer

PLANNING COUNCIL GENERAL SESSION

Sierra Ballroom

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Josephine Black, Chairperson	
1:40 p.m.	Opening Remarks	Uma Zykofsky, Deputy Director, Sacramento County Behavioral Health	A
2:00 p.m.	Approval of Minutes from June 2016 meeting	Jo Black, Chairperson	B
2:05 p.m.	Overview of Status and Next Steps of Integration of Co-Occurring Substance Use	Susan Wilson, Chair, BH Steering Cmte and Jane Adcock, Executive Officer	
2:15 p.m.	CA Consortium of Addiction Programs and Professionals	Pete Nielsen, CEO and Sherry Daley, Senior Gov't Affairs Director	C
2:50 p.m.	Council Member Questions and Discussion	All	
3:00 p.m.	Public Comment	Jo Black, Chairperson	
3:05 p.m.	Break		

California Mental Health Planning Council

3:20 p.m.	Adult Residential Care for Substance Use Disorders and Co-Occurring Mental Health and Substance Use Disorders	Kathrina Cauckwell, MSW, of WellSpace Health. Diana White, Al Rowlett and Leslie Springer, of Turning Point Community Programs	D
4:10 p.m.	Council Member Questions and Discussion	All	
4:30 p.m.	Update on Workforce Education and Training Ad Hoc Efforts	Tom Orrock	
4:40 p.m.	Public Comment	Jo Black, Chairperson	
4:50 p.m.	Volunteers for Nominating Committee	Jane Adcock, Executive Officer	E
5:00 p.m.	Recess		

Thursday, October 20, 2016

COMMITTEE MEETINGS

Time	Event	Room	
7:30 a.m.	Children's Caucus	Hotel Restaurant	
8:30 a.m.	Advocacy Committee	Folsom	
to 12:00 p.m.	Continuous System Improvement	Natoma	
	Health Care Integration Committee	Placer	
12:00 p.m.	LUNCH (on your own)		

PLANNING COUNCIL GENERAL SESSION

Sierra Ballroom

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Josephine Black, Chairperson	
1:40 p.m.	Panel on Use of Psychotropic Medications for Foster Youth	CA State Auditor (invited), Lori Fuller, Chief, Permanency Policy Branch, CDSS and a former Foster Youth	F
2:40 p.m.	Council Member Questions and Discussion	Josephine Black, Chairperson	
2:50 p.m.	Public Comment	Jo Black, Chairperson	
3:00 p.m.	Break		

California Mental Health Planning Council

3:15 p.m.	Panel re: Implementation of Continuum of Care Reform	El Dorado, Yolo, Trinity, Sacramento, and San Joaquin Counties (invited)	G
4:10 p.m.	Council Member Questions and Discussion	All	
4:20 p.m.	Public Comment	Jo Black, Chairperson	
4:30 p.m.	Report from CA Behavioral Health Directors Association	Noel O'Neill, Director, Trinity County	
4:50 p.m.	Executive Officer's Report	Jane Adcock	
5:00 p.m.	Recess		

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

Friday, October 21, 2016

PLANNING COUNCIL GENERAL SESSION

Sierra Ballroom

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Welcome and Introductions	Josephine Black, Chairperson	
8:40 a.m.	Report from the California Association of Local Behavioral Health Boards/Commissions	Cary Martin, President	
9:00 a.m.	Committee Reports – Patients' Rights, Health Care Integration, Continuous System Improvement, Advocacy	Daphne Shaw, Chair PRC Terry Lewis, Chair HCI, Lorraine Flores, Chair CSI, Darlene Prettyman, Chair Advocacy	
9:55 am	Public Comment	Jo Black, Chairperson	
10:05 a.m.	BREAK		
10:20 a.m.	Report from Mental Health Services Oversight and Accountability Commission	Toby Ewing, Executive Director	
10:45 a.m.	Council Discussion of Little Hoover Report on MHSA	All	H
11:00 a.m.	Trauma Informed Care for Children and Youth	Laura Heintz, CEO, Stanford Youth Solutions	I
11:50 a.m.	Public Comment	Jo Black, Chairperson	
11:55 a.m.	Meeting Evaluation	All	

California Mental Health Planning Council

12:00 p.m.	ADJOURN		
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All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.

If Reasonable Accommodation is required, please contact Chamenique Williams at 916.552.9560 by October 6, 2016 in order to work with the venue to meet the request.

2017 MEETING SCHEDULE

January 2017	January 18, 19, 20	San Diego	Courtyard Marriott 595 Hotel Circle South San Diego, CA 92108
April 2017	April 19, 20, 21	San Jose	Holiday Inn San Jose- Silicon Valley 1350 North 1 st Street San Jose, CA 95112
June 2017	June 14, 15, 16	Orange	Atrium Hotel 18700 MacArthur Blvd, Irvine, CA 92612
October 2017	October 18, 19, 20	Sacramento	To Be Determined

California Mental Health Planning Council

Executive Committee

Wednesday, October 19, 2016

Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630

**Folsom Room
9:00 to 10:30 a.m.**

Time	Topic	Presenter or Facilitator	Tab
9:00	Welcome and Introductions	Josephine Black, Chairperson	
9:05	June 2016 Executive Committee Minutes	Jo Black, Chairperson	1
9:10	FY 2015-16 Council Budget and Expenditures and Update on Contract Solicitations	Tamara Jones, Chief of Operations	2
9:15	Overview and Discussion of Little Hoover Report	Jane Adcock and All	3
9:35	Discussion of Council Retreat for Development of Council Brand, Mission, Direction, etc	Jane Adcock and All	4
10:05	Liaison Reports for CA Assoc of Local MH Boards/Commissions and CA Coalition for MH	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.

Executive Committee Members:

Officer Team	Jo Black	Susan Wilson	Cindy Claflin
Advocacy Cmte	Darlene Prettyman	Maya Petties	

California Mental Health Planning Council

CSI Cmte	Lorraine Flores	Walter Shwe	
HCI Cmte	Terry Lewis	Robert Blackford	
Patients' Rights	Daphne Shaw	Cindy Claflin	
Liaisons	Daphne Shaw, CCMH	Susan Wilson, CALBHB/C	Noel O'Neill, CBHDA
At Large	Arden Tucker, Consumer		
Executive Officer	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

Patients' Rights Committee

October 19, 2016

Lake Natoma Inn, Placer Room

702 Gold Lake Drive Folsom, CA 95630

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

Time	Topic	Presenter or Facilitator	Tab
11:00 a.m.	Welcome and Introductions	Daphne Shaw, Chair	
11:05	Agenda Review	Daphne Shaw, Chair	
11:10	Review and approve June 2016 meeting minutes	Daphne Shaw, Chair	A
11:15	Discuss Issue of Ratio of Patients' Rights Advocates, training requirements, and update on Humboldt Co. investigation. Report out from 8/24 CAMHPRA meeting.	Samuel Jain, Mental Health Advocacy Project Daphne Shaw, Chair All	B
12:00	Review Projects on Work Plan and revise as necessary	All	C
12:10	Review PRA Survey draft	All	D
12:20	Plan for Next Meeting/Report Out	All	
12:30	Public Comment/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 Walter Shwe
 Carmen Lee Richard Krzyzanowski

Staff: Tom Orrock Jane Adcock, EO

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

California Mental Health Planning Council

Advocacy Committee
Thursday, October 20, 2016
Lake Natoma Inn
702 Gold Lake Drive
Folsom, California 95630
Folsom Boardroom

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

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Darlene Prettyman, Chairperson	
8:35	Agenda Review	Darlene Prettyman	
8:40	Approval of Minutes from June, July, August and September 2016	Darlene Prettyman and All	A
8:45	Legislative and Regulatory Updates related to Mental Health may be discussed, including but not limited to: Legislation Active List, etc.	Darlene Prettyman and All	B
9:05	Work Plan: County Questionnaire and AB 109 and RCF Draft Papers	Darlene Prettyman and All	C
10:05	Break		
10:20	Charter and Policy Platform	Darlene Prettyman and All	D
10:40	Michael Saigon, Deputy Sheriff, Sacramento County, Youth Services Unit - Sacramento Sheriff's Community Impact Program	Deputy Sheriff Saigon and All	E
11:50	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
Lake Natoma Inn
702 Gold Lake Drive, Folsom, CA 95630
October 20, 2016
Placer Boardroom - 8:30am – 12:00pm

Time	Topic	Presenter or Facilitator	Tab
8:30am	Planning Council Issue Requests	All members	
8:35am	Welcome and Introductions	Lorraine Flores, Chair Walter Shwe, Chair-elect	
8:40am	Review/Approve July minutes	All members	A
8:50am	Data Notebook 2016: Progress and Timelines	Linda Dickerson, Susan Wilson	
9:20am	Work Plan Review	Lorraine Flores, Chair	B
10:00am	Break		
10:15am	Presentation: Substance Abuse Programs for Youth	Dr. BJ Davis, Executive Director of Strategies4change Sack Keophimane	
11:05am	Homeless Youth and LGBTQ report update	Lorraine Flores, Tom Orrock Sack Keophimane	
11:30am	Public Comment		
11:35am	Evaluate meeting and develop next meeting agenda	Lorraine Flores, Chair	

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, Amy Eargle

If reasonable accommodations are needed, please contact the CMHPC at (916) 552-9560 no less than 5 working days prior to the meeting date.

California Mental Health Planning Council

Healthcare Integration Committee

Thursday, October 20, 2016

Lake Natoma Inn

702 Gold Lake Drive Folsom CA 95630

ROOM: Natoma Boardroom

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
9:00 a.m.	Presentation: Health Plan: Psychotropic Medication, impact on Youth/Children and Families, and alternatives to medication	Health Plan, <i>Invited</i>	B
9:45 a.m.	Questions/Comments	All	
10:15 a.m.	Break		
10:30 a.m.	Review CMHPC HCI Alternatives to Medication Chart: Work Plan Goal 2: Explore the health effects of psychotropic Medications on Children and alternatives to medication (Objective 2: Research innovative practices counties and mental health plans are doing and alternatives to medications for children)	Staff Deborah Pitts, CMHPC Terry Lewis, Chairperson	C
11:00 a.m.	Review and Approve: HCI Report: Medi Cal Coverage of Mild to Moderate Mental Health Conditions	Terry Lewis, Chairperson	D
11:20 a.m.	Choose 2017 Chair Elect	All	
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.

California Mental Health Planning Council

Committee Members:

Chair:

Terry Lewis

Chair-Elect:

Robert Blackford

Members:

Cindy Claflin

Gail Nickerson

Dale Mueller

Josephine Black

Patricia Bennett

Peter Harsch

Steven

Cheryl

Melen Vue

Grolnic-McClurg

Treadwell

Daphyne Watson

Vera Calloway

Deborah Pitts

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

A TAB SECTION

DATE OF MEETING 10/19/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 9/16/16

AGENDA ITEM:	Opening Remarks from Sacramento County
ENCLOSURES:	

BACKGROUND/DESCRIPTION:

Sacramento County Behavioral Health has an array of mental health services available for children and youth.

This list comes from their website at

<http://www.dhhs.saccounty.net/BHS/Pages/Childrens-Mental-Health/Childrens-Mental-Health.aspx>

Children's Mental Health Services

We provide a full array of culturally competent and linguistically proficient mental health services to children and youth ages 0-21 years. Services include prevention and early intervention services; outpatient services; case management; crisis intervention and stabilization services; and inpatient psychiatric hospitalization.

How to Access Children's Mental Health Services

The *Mental Health Access Team* is the entry point for mental health services for children and youth ages 0-21 years. The *Mental Health Access Team* conducts over the phone triage, assessments, and linkage/referral to county-operated or contracted mental health service providers.

Mental Health Access Team

Monday - Friday
8:00 a.m. - 5:00 p.m.
Phone: (916) 875-1055

The Children's Mental Health Services we provide include:

Acute Psychiatric Emergency Services

[Crisis Intervention and Stabilization](#)

[Inpatient Hospitalization](#)

Early Childhood Mental Health Services

[HEARTS for Kids](#)

[Infant Mental Health Services](#)

[Parent Child Interaction Therapy](#)

[Quality Child-Care Consultation Team](#)

Group Homes

[Rate Classification Level \(RCL\) 12 and RCL 14 Group Homes](#)

Intensive Mental Health Services

[Fast Track Program](#)

[Flexible Integrated Treatment](#)

[Intensive Treatment Foster Care](#)

[Pathways](#)

[Residential Based Services](#)

[Therapeutic Behavioral Services](#)

[Transcultural Wellness Center](#)

[Wraparound Services](#)

Juvenile Justice Mental Health Services

[Family Child Community Treatment Program](#)

[Juvenile Justice Diversion Treatment Program](#)

[Juvenile Justice Institutions](#)

[Multi-Systemic Therapy Program](#)

[Sacramento Assessment Center](#)

Outpatient Mental Health Services

[Child and Adolescent Psychiatric Services Clinic](#)

[Child Protective Services/Mental Health \(CPS/MH\) Assessment Team](#)

[Children's Mental Health & Alcohol or Other Drug Specialization](#)

[Counseling, Rehabilitation, and Medication Support](#)

[Psychological Testing](#)

[Suicide Prevention](#)

[Transition Age Services](#)

[Transitional Housing Program](#)

B TAB SECTION

DATE OF MEETING 10/19/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 9/14/16

AGENDA ITEM:	Approval of Minutes from June 2016 meeting
ENCLOSURES:	Draft Minutes of the June 2016 meeting

BACKGROUND/DESCRIPTION:

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

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

**June 15-17, 2016
Ontario Airport Hotel
700 N. Haven Avenue
Ontario, CA 91764**

CMHPC Members Present:

Josephine Black, Chair	Raja Mitry
Susan Wilson, Chair-Elect	Dale Mueller
Patricia Bennett	Adam Nelson
Robert Blackford	Noel O'Neill
Vera Calloway	Gail Nickerson
Lorraine Flores	Maya Petties
Steven Grolnic-McClurg	Deborah Pitts
Peter Harsch	Darlene Prettyman
Karen Hart	Peter Schroeder
Celeste Hunter	Daphne Shaw
Carmen Lee	Walter Shwe
Terry Lewis	Cheryl Treadwell
Esmeralda Liberato	Daphyne Watson
Barbara Mitchell	

Staff Present:

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

Wednesday, June 15, 2016

1. Welcome and Introductions

Chair Black called the meeting to order and welcomed everyone. Planning Council members, staff, and audience members introduced themselves.

Executive Officer Adcock requested a moment of silence to honor the fallen and wounded LGBTQ comrades in Orlando, Florida.

2. Opening Remarks

CaSonya Thomas, Director of the San Bernardino County Department of Behavioral Health, welcomed the Planning Council to San Bernardino County. Ms. Thomas focused her comments on the resilience, determination, and importance of community mental health.

Ms. Thomas shared demographics of the county.

The Behavioral Health budget, which includes Substance Use, Realignment, and the Mental Health Services Act (MHSA), is \$400 million. They have over 1,000 county employees and provide services primarily through the support of a comprehensive contract provider network.

After the December 2nd shooting, the Department of Behavioral Health's ability to respond in support of fellow county employees became even more important. One of the first calls that the Director of Public Health made was to Ms. Thomas' office in order to obtain help for the affected staff.

The county has invested MHSA funding to develop a Community Crisis Response Team. It is mobile and 24/7. Almost all of the staff of the Division of Environmental Health had been present at the shooting; they were injured physically or emotionally, and some lost their lives. The Community Crisis Response Team provided support to those individuals. The Department of Behavioral Health, because of their investment in support of MHSA and other resources, did not need to pull personnel from clinics during that time.

Although county operations were closed that Thursday and Friday, Behavioral Health staff continued to come to work and provide services. Clients who had appointments on those days had their needs met.

Behavioral Health has developed a best practice in which liaisons are assigned to every impacted person. Six months later, the liaisons continue to support staff and family. Not all of the liaisons were clinical; they were also individuals familiar with the Human Services system with good organizational and communication skills.

Through this experience, Behavioral Health learned a lot about "vicarious trauma" associated with providing services to others. The lessons will continue in the months and years ahead on the impacts of vicarious trauma on the Community Crisis Response Team and the liaisons.

Recently, Behavioral Health worked with the DA's office to submit grants under the Victims of Crime Act (\$400,000) and Anti-Terrorism (\$2.3 million). Those funds will be targeted toward community forums to provide additional training.

The county has joined the exclusive club of communities who have experienced tragedies like this, but the federal dollars and mutual aid have not come. The community developed an SB United Relief Fund of \$2.5 million; those funds were disbursed to injured individuals and families of the deceased. This amount pales in comparison to the amount other communities received. San Bernardino has been able to respond as it has due to the advocacy and support of the Legislature and the Governor.

An exciting opportunity has been the SB 82 Investment in Mental Health Wellness. San Bernardino County has been successful in four of the five rounds. With those funds they will develop four additional crisis residential treatment programs. The county has about six Lanterman-Petris-Short Act-designated hospitals with a need for additional levels of care, so we are pleased to bring on the crisis stabilization units and crisis residential treatment programs.

Regarding Continuum of Care Reform (CCR) AB 403, the county has a good working relationship between the Department of Behavioral Health and Children and Family Services.

Questions and Discussion

Ms. Shaw commented on how much things have changed since the 80s, when children were killed and wounded on school grounds in Stockton. No one at that time thought to notify mental health services immediately.

Ms. Lee asked about the number of beds in the six hospitals and whether they have an Institution for Mental Disease (IMD). Ms. Thomas responded that there is an IMD with whom the county contracts. In the county hospital there are 74 beds, and they contract with other hospitals; they are in competition with neighboring counties for those beds.

Ms. Lewis asked about the additional funding after the shooting that had not arrived from the federal government. Ms. Thomas replied that California has an Office of Emergency Services; the county is tallying its costs, but some are not reimbursable. The front impact is an outlay of over \$20 million, some of which can be reimbursed through the Office of Emergency Services. For mental health services, because the county reassigned already-existing resources, it is unlikely that they will see federal reimbursement.

Ms. Lewis asked if letters of support would help. Ms. Thomas said that there is still work ahead between the California Legislature and the Chief Executive Officer. As he becomes more familiar with the response to other communities, he will realize that the county needs an added investment in outreaching to both the state and the federal governments. San Bernardino County had been fortunate to have the existing infrastructure and leadership to respond in the way it has.

Mr. O'Neill asked how long the department's formal support of the community will continue. Ms. Thomas replied that there is a liaison team for the families of the deceased and injured, and a liaison team for the people who were actually in the room. Each is led by a licensed clinical mental health professional. The teams themselves are continuing to receive mental health support.

Ms. Mueller, an RN and Professor of Nursing in San Bernardino County, spoke about her experience during the shooting incident – communication was effective and the community has been resilient.

3. Overview of San Bernardino County Substance Use Services and Programs

Veronica Kelley, LCSW, Assistant Director, San Bernardino County Department of Behavioral Health, gave a presentation on the Substance Use Disorder (SUD) system of care in that county.

- The Department of Health Care Services (DHCS) is responsible for ensuring that Medi-Cal beneficiaries have access to affordable and integrated health care, including mental health and SUD.
- The Division of Mental Health & Substance Use Disorder Services is responsible for overseeing the county.

- Ms. Kelley described the Drug Medi-Cal benefit. It will change with the Drug Medi-Cal Waiver Organized Delivery System, which will allow the county to bill for additional services.
- Ms. Kelley gave national figures for numbers of Americans with SUD and mental illness. She gave figures for schizophrenia and Co-Occurring Disorders (CODs). She explained the relationships between schizophrenia and nicotine use, and schizophrenia and marijuana.
- Ms. Kelley spoke about Major Depressive Disorder, Bipolar Disorder, and Post Traumatic Stress Disorder and explained why they must be treated along with the SUD.
- She explained releases of dopamine in the brain from substances and activities.
- Prevention is very important to county systems; she explained funding.
- Treatment includes outpatient, residential, perinatal, detox, withdrawal management, methadone, and Intensive Outpatient Treatment. Drug addiction is the symptom of SUD. The state of California is trying to shift to more science, not morality. The Drug Medi-Cal Waiver will allow the counties to start to treat disorders.
- Ms. Kelley described recovery support services, which involve transition. They will be covered by the Drug Medi-Cal Waiver, as will case management and physician consultation.
- Special programs include Partnership for Healthy Moms and Babies, and Drug Court.
- California's integration of SUD and mental health is being watched by the rest of the nation, so it is imperative to do a good job as we opt into the Waiver. We need to support the integration of recovery. Mental health and full-blown addiction have to be addressed at the same time.

4. Council Questions and Discussion

Dr. Bennett asked about a young person who is self-medicating as a result of trauma or depression – how do you identify and treat the problem? Ms. Kelley answered that they do trauma-informed therapy and emphasize the relationship between the clinician and the client, in particular with youth. They do an in-depth assessment and focus on evidence-based practices that have been tried only on youth.

Mr. Mitry asked about determining early intervention versus treatment in an older adult experiencing temptation to use heavy drugs such as meth, due to critical life changes. Ms. Kelley answered that the older adult specialty programs focus specifically on assessment, because addiction and substance misuse will appear differently according to culture and generation. Treatment may involve education or drug-free social situations.

Mr. O'Neill asked about the integration of the Mental Health Department with the Alcohol and Other Drug Department. Ms. Kelley said that they have emphasized a culture of integration where one is no better than the other. They have brought clinicians,

counselors, and physicians together to reveal and appreciate differences in knowledge. The process of integration is challenging and sometimes painful.

5. Public Comment

There was no public comment.

6. Approval of Minutes from April 2016 Meeting

Motion: Barbara Mitchell moved to accept the April Minutes; seconded by Maya Petties. Motion carried with Ms. Hart and Dr. Bennett abstaining.

7. Approval of 2016 Policy Platform

Ms. Prettyman stated that the Advocacy Committee had been working on the 2016 Policy Platform for quite some time. They had renamed it from the “Legislative Platform.” It had gone through many revisions, but the committee was pleased with the result.

Motion: Barbara Mitchell moved to accept the 2016 Policy Platform; seconded by Peter Schroeder.

Mr. Mitry asked if the Planning Council will take on the next Policy Platform in 2017. Executive Officer Adcock affirmed. The Advocacy Committee will likely make additions for next January; it will then be in effect for two years. Mr. Mitry stated that he had some suggestions for the document. Executive Officer Adcock stated that the committee would work with Mr. Mitry over the next six months; for today they hoped to adopt the new document, as the current one was very out-of-date.

Ms. Hart asked about the omission of *wellness* from #7 on page 2. The committee agreed to add this term.

Ms. Flores recommended placing #13 and #15 together at the end.

Dr. Nelson stated that it would be appropriate to vote on the document as it had been presented. Any requested changes should be done subsequent to the vote.

Roll Call Vote: The members voted unanimously to accept the 2016 Policy Platform as presented.

8. Recovery Lifestyles Program, an SUD Treatment Program at Patton State Hospital

Dr. Troy Freimuth, Psy.D., Forensic Psychologist at Patton State Hospital, spoke about the Recovery Lifestyles Program (RLP) which he designed in 2012.

Patton State Hospital is the largest forensic psychiatric hospital in the world with 1500 patients, most of whom have severe mental illness. About half of what the hospital deals with is “Incompetent to Stand Trial.” People who are Not Guilty by Reason of Insanity (NGI) are also hospitalized at Patton. Mentally disordered offenders may be paroled at Patton. Mentally ill prisoners may be stabilized at Patton, then returned to prison.

The campus is very large in size. Dr. Freimuth described the layout.

Dr. Freimuth described the recent history of substance abuse treatment at Patton.

He trained in motivational interviewing (an evidence-based substance abuse recovery treatment considered best practice in forensic settings) and group motivational interviewing (a treatment designed to help people move forward in their stages of change).

Dr. Freimuth described the program itself.

- He wanted the program to become integrated throughout the hospital – to have the involvement of not just the specialized alcohol and drug counselors, but also the Patton clinicians.
- He developed an “affiliated provider program” that brought other clinicians under the RLP umbrella – providing them with oversight, training, and mentoring. He leaned heavily on a newly-created motivational interviewing team.
- Staff includes psych techs, a nurse, and a clinical psychologist working to bring the program hospital-wide.
- Dr. Freimuth also developed creative arts/motivational arts, which combined literature, music, and art therapy with motivational interviewing. It provided a way to engage some patients who were not interested in groups.
- An Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) Coordinator partnered with Dr. Freimuth to develop foundational 12-step groups that could prepare the patients for the evening meetings.
- RLP affiliate providers, who had trained with Dr. Freimuth’s staff, would do guest lectures and training.
- RLP could serve about 350 patients at a time, an increase from about 30 with previous programs.
- Dr. Freimuth described Prochaska and DiClemente’s Stages of Change model: the individual goes through a series of steps from pre-contemplation to maintenance of the changes. People can move forward and backward in their change process. The program is designed to address patients at the different stages. Techniques need to be different at each separate stage.
- Different interventions were designed for the different stages.
 1. Early stage groups were primarily motivational interviewing groups, relying heavily on the music and art motivational group, as well as traditional interviewing process groups.
 2. The Intermediate group was open recovery – centrally located and designed for patients a little further on.
 3. The Intensive Program was designed as closed enrollment, so that the recovery process could happen in a community. It was a six-month program. There were two branches: the Skills program for patients with more psychological and cognitive challenges, and the Principles program for patients who could process information more easily.

4. The Aftercare (or Maintenance) program worked to reinforce and maintain changes.
 - For the early stages, Dr. Freimuth wanted an outreach approach, which is used more in severely mentally ill populations. The groups are brought from the central location at Patton into the locations where patients are housed.
 - Enrollment was very easy.
 - The Intensive Program was envisioned as the heart of RLP. It used an extensive treatment model; research is showing that the duration of treatment is relatively more important than the intensity.
 - Patients were assigned case managers who “shepherded” their flocks through the program. The psychological approach was positive and supportive.
 - The goal of the Intensive program was a lifestyle change – in how the person looks at the world, feels, thinks, relates, responds, manages stress, has fun – learning to live life on life’s terms. There was also a spirituality component.
 - For the core curriculum, Dr. Freimuth borrowed heavily from Dialectical Behavior Therapy to teach social skills; it is helpful for people with affective problems, interpersonal problems, and self-harming behaviors.
 - Smart Recovery, which was more cognitive/behavioral, was for the people put off by some of the spiritual aspects of AA/NA. It was a community program with motivational interviewing throughout the program.
 - Five main pillars framed the treatment:
 1. Motivational interviewing – no confronting or shaming
 2. Positive psychology to bring out a person’s strengths
 3. Affective motivational models that look at why people use alcohol and drugs – it is emotional – to feel good or to get rid of bad feelings
 4. Spirituality
 5. Skills-based approaches
 - Patients received a lot of feedback via “report cards.”
 - Halfway through the program there was an open house; at 24 weeks there was a huge celebration with family members attending.
 - Initially a placement assessment was done using the motivational interviewing framework of “less is more” – the team was more interested in engagement than assessment, although they did use portions of the Addiction Severity Index for assessment. The placement assessment took about an hour.
 - For Aftercare, the patients could take courses such as Smart Recovery, AA/NA, Relationships, Community Integration, and Advanced Recovery Topics. About a year of continuous treatment is needed for optimal outcomes.

- The goal for the After the Aftercare program was patients getting back to their community and culture, taking leadership roles, positively impacting the community. Unfortunately, this goal hit bureaucratic and administrative hurdles.
- An evidence-based program should evaluate outcomes. Early on the program made use of satisfaction surveys, which are highly predictive of outcome. About 90% of the patients scored the program as excellent – the patients were the best marketers.
- Pre- and post-testing was done using the brief version of the Barratt Impulsiveness Scale. The CORE-OM, an evidence-based instrument consisting of 34 items, was also used. Drop-out rates were about 20%. Of the remaining patients who stayed in, about 95% graduated.
- They brought a few Spanish-speaking patients through the program by translating material. For the Spanish unit at Patton, RLP became a consultant of sorts, bringing them materials and helping them provide treatment. The situation was not optimal because those clinicians were not so much a part of the program, and the patients were not able to enter the Intensive Program.
- For the Medically and Psychologically Fragile specialty unit, the team also tried to do what they could. One deaf patient came through the program.
- The staff was quite diverse and much cultural and ideographic training was done.

Questions and Discussion

Mr. Mitry asked if any Native American healers had been brought in to work with the Native American individuals. Dr. Freimuth replied that RLP had partnered with Patton's Native American chaplain, who provided education for staff and led some groups.

Mr. Mitry asked how RLP addressed self-stigma where individuals are tormented by shame. Dr. Freimuth answered that a huge part of the program was de-shaming. (The approach of some traditional programs actually created shame by negative labeling or confronting.) The program had self-esteem and identity components. Patients were coached and encouraged to share their stories.

Ms. Lee asked how long it takes someone to go through the program successfully and reach Aftercare. Dr. Freimuth stated that the whole program is designed to be at least one year of continuous treatment.

Dr. Eargle asked if patients were accepted into the program regardless of their release date, or were screened by when they were likely to get out. Dr. Freimuth answered that it was a real challenge. He did accept some patients with an imminent release date, so they could get some time in the program. In addition, there were shuttling issues and safety issues.

Dr. Petties asked for any recommendations to the unit, which is the patient's community, that would help facilitate the success of the program. Dr. Freimuth replied that it would be interest and involvement of the treatment teams – collaboration and integration.

Chair Black asked about Dr. Freimuth's use of past tense – is the program continuing? Dr. Freimuth answered that six months ago he had decided to get back into the treatment end and handed the program over to someone else to oversee.

Chair Black commented on the idea of therapy dogs. Dr. Freimuth stated that many therapy dogs are used at Patton. Their use is expanding at California Department of Corrections and Rehabilitation.

Ms. Calloway asked if the 20% who dropped out were given an opportunity to try again. Dr. Freimuth responded that it took some patients four attempts to complete the program. He viewed the dropouts as progress rather than failure. Some patients were not used to talking about themselves, and being in a community-type environment. The vast majority dropped out due to negative symptoms of schizophrenia; they couldn't tolerate that degree of treatment.

Ms. Flores inquired about follow-up after patients left the program in terms of sustaining gains. Dr. Freimuth has been trying to do follow-up when the patients leave the institution but it's difficult. The advantage at Patton is that they are a captive audience – kind of an intensive outpatient environment within a residential facility.

Mr. Harsch asked about figures from other treatment programs after the patients' release. Dr. Freimuth replied that the Video Arts Director had gone out and interviewed patients after release and gotten testimonials from them. Getting data from other unconnected organizations hasn't been accomplished, although it would be very helpful to know.

Ms. Hart asked about the age range. Dr. Freimuth answered that they treated teens through 70-year-olds. The typical age was 40 to 50 years old.

Ms. Liberato asked if they planned to go back to the Spanish-speaking community. Dr. Freimuth replied that Spanish is the next most prevalent language at Patton. He had continually asked for a bilingual Spanish speaker on the staff, but the budget decreased a bit and his request was unsuccessful.

Ms. Lee commented that years ago her hearing impairment had been diagnosed in a state hospital. Dr. Freimuth was not as familiar with the process in the deaf unit. There are speech therapists and services.

10. Public Comment

There was no public comment

Ms. Wiseman suggested to the members that they email any 2016 Policy Platform edits to her.

Thursday, June 16, 2016

1. Welcome and Introductions

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

2. Overview of California's Child Welfare Continuum of Care Reform

Cheryl Treadwell, Chief Foster Care Rates and Audits Branch, California Department of Social Services (CDSS), gave a presentation about reform efforts currently underway there according to AB 403.

In 2013 there was a legislative mandate for CDSS to look at reforming group homes and the foster family agency system. An 18-month workgroup produced a report with recommendations on how to proceed.

- The vision is as follows.
 - For all the kids to have nurturing and permanent homes.
 - To have more coordinated services between all of the agencies involved.
 - For those who stay in the system, to focus on preparing the kids for adulthood.
 - To ensure that when kids must go into group care, they are there only for short-term intervention.
- The guiding principles are as follows.
 - Every child should have an assessment.
 - Every child should have thorough services in case planning.
 - Placement decisions will be made by a team.
 - Kids shouldn't have to move to get services; we bring services to kids. This is a huge shift from the current system.
 - This is a cross-system, cross-agency effort; CDSS works closely with health care services, education, probation, and juvenile justice partners.
- There are two systems: home-based family care and a short-term residential therapeutic treatment program.
- It is all grounded in a child and family team, the complexity of which is defined by the family.

About 5,800-6,000 kids are currently in group care statewide, including child welfare and probation. There are about 350 group homes with a capacity to serve about 7,500 kids. Statewide there are about 220 foster family agencies (FFAs).

The landscape is changing and the number of kids in foster care is going down. The ones that agencies need to work with are the relatives. CDSS is trying to increase engagement by having more child and family teams, and doing more assessments (mental health screening that is comprehensive) with the family.

CDSS has developed a Core Practice Model. The goal is that when families come into contact with the mental health system and CDSS, they have the same experience.

All FFAs and short-term therapeutic programs now must make core services available, including mental health, transitional, education, and physical health. All FFAs must be accredited by one of three nationally recognized accreditation agencies.

The term “resource families” will refer to FFA foster homes, county foster homes, and relatives. This is a big shift in terms of culture. FFAs will be required to provide services to relatives.

All foster families will be licensed the same way and receive the same kind of training. All will be given a psycho-social assessment. This streamlines the process for families who choose to adopt.

A new category has been created for group homes: short-term therapeutic programs. At some point county-operated shelters will no longer be needed, but the counties must come up with a plan for how they will transition.

The law now requires Probation to work closely with CDSS to identify what families need to know to take probation kids into their homes.

The rate structures have changed. For the group home level, there will no longer be Rate Classification Levels – they will be paid a single rate and will be expected to do a lot.

The home-based agency system will be based on a level of care set by what kids need. CDSS hopes to leverage Katie A. to build more therapeutic foster homes.

CDSS is developing a performance and outcome system for providers – a dashboard to see how they are doing on outcomes.

The effective date for implementation of all the changes in requirements is January 1, 2017. The Governor’s Office has committed a lot of resources to CDSS and its partners, to ensure that the right infrastructure goes forward.

Questions and Discussion

Ms. Prettyman asked Ms. Treadwell to describe a short-term residential therapeutic program. Ms. Treadwell stated that group homes at the rate classification level of 14 take kids that fall at the highest end of the spectrum of mental health needs. Those homes offer intense therapeutic services. Once the kids have stabilized, they go back to their placement. Kids will not grow up in group homes anymore.

Ms. Prettyman asked about therapeutic programming. Ms. Treadwell answered that CDSS asks providers to look at evidence-based practices – things that work for youth – tailored to their needs based on their individual plans.

Dr. Baylor added that they want to focus on trauma as well. The CDSS view on trauma is that the kids are not severely mentally ill; they just do not have skills and need additional coaching and skill-building on things that trigger their trauma.

Dr. Bennett noted that many children enter the child welfare system and then graduate into the juvenile probation system. Does any of this framework prevent that from happening? Ms. Treadwell answered that all that she had described for Child Welfare is also available for Probation. In the new system, the expectation is that teams are making critical decisions about kids early on.

3. Panel Re: Mental Health Services to Children in Foster Care Including Under the Katie A. Court Order

Ms. Wiseman introduced the five panelists:

Samira Washington, a 20-year-old college student

Horacio Diaz, a provider and social worker in San Bernardino County

Syrena Morek, a new college student

Maria Mota, Court Appointed Special Advocates (CASA) volunteer

Valerie Valdez, CASA Advocate Supervisor

Ms. Washington shared her story first. While in foster care she had many mental health issues such as anxiety, depression, and at one point hallucinations. She had support from counselors who were there for her at first, but then abandoned her. Going to school is what worked for Ms. Washington. Education is her life; it keeps her happy. School counselors remind her that if she keeps pushing herself, she'll make it further.

Ms. Morek shared her story next. She had been in foster care since the age of five and grew up in group homes. She was diagnosed with a lot of mental issues. Once she turned 18, she stopped therapy. Meds helped somewhat, as did CASA and some of the group home staff. Having more people there for the youth, coming in and staying there rather than leaving, would have helped. Ms. Morek lived in three foster homes and three group homes. Therapy had not helped.

Mr. Diaz stated that he has been a social worker for San Bernardino County Children and Family Services for 15 years. He has also been a foster parent for three years.

Mr. Diaz described his relationship with a current foster youth who has been in his care for about eight months. The youth is unpredictable from day to day in how he responds to Mr. Diaz. The youth has mental health issues and if he is in a bad mood, he will take any interaction negatively and become aggressive. He also has substance abuse issues. The youth did graduate from high school and is registered to attend the local college. He agrees to receive mental health services but then figures out a way to get out of them.

Ms. Lee commented that if someone had initially talked to both Mr. Diaz and the foster teen about what to expect, it would have helped a great deal. Mr. Diaz agreed that it would have been helpful to hear his history, his triggers, what worked and didn't work with him. Confidentiality laws can actually result in barriers.

Ms. Mota shared her story working with Ms. Morek for the past 15 months. Ms. Morek stopped therapy in June 2015 because she felt that it was not helping – her friends and family were helping her control her behavior and become mature. Ms. Morek felt that she should not have been taking so much medication.

Ms. Mota felt that if there had been more permanency and consistency in Ms. Morek's life, it would have been a better way to solve her issues. One of her foster parents had commented on not being prepared to take on some of her issues and behaviors. Ms. Mota said that having the moral support of family had helped Ms. Morek. Her focus on school has also helped – she is starting community college this summer.

Ms. Wiseman asked Ms. Morek if she had ever been part of the planning for her medication treatment; did she feel that she was overmedicated? Ms. Morek responded

that she had not gotten a choice. She felt as if she was being medicated to control the behavior. She is currently taking four medications.

Ms. Valdez, the CASA supervisor, noted that she had been a part of Ms. Morek's life since 2008. An adoption plan with a foster family had fallen through because of some of Ms. Morek's behaviors. She had been on six different medications at that time but was not in therapy, which is why CASA was continuously advocating for a re-evaluation of the medication as well as some counseling or therapy. Ms. Valdez said that much of CASA's advocating comes in asking the courts to provide a different therapist for the kids when they don't connect with the first one.

Ms. Morek said that she has been on medication since the age of five. She didn't like therapists putting her back on the same medication she took when she was younger, when she was pulling out her eyelashes and her hair. Every different medication would just make her worse and she had no say-so. Her label of having ADHD, anxiety, hallucinations and depression has followed her since she was small. She stressed that no one ever listened to her.

4. Council Questions and Discussion

Ms. Prettyman asked if CASA also works with social workers. Ms. Valdez replied that they work with everyone involved with the youths' lives – caregivers, attorneys, social workers, therapists, teachers.

Ms. Prettyman asked how often the volunteers visit with their clients. Ms. Valdez answered that every relationship is different – it depends on schedules – but CASA asks for 10-15 hours per month. The CASA volunteers as well as their supervisors go to court for the clients.

Ms. Flores apologized to the two foster panelists for what they have experienced in the foster care system. She has run a Level 14 for 22 years with 30 kids. No matter how much they loved and tried to support them, she looks back now and sees that damage was caused. Ms. Flores commented on the resilience of foster youth. She thanked the two foster youth for coming and sharing their invaluable information so that we can improve the way we take care of our children.

Ms. Liberato encouraged the panel presenters to speak up, especially to their psychiatrists. They have a voice and they can help someone else going through the same situation. Ms. Liberato understood how difficult it is to advocate for yourself.

Ms. Calloway spoke as an adult consumer who wished she had received therapy when she was young. She asked the two foster youth about their best and worst placements. Also, in their current situations, do they avail themselves of peer support? Ms. Washington answered that she had never had a good placement and did not have any peer support. She did have the two supporters on the panel.

Ms. Morek said that Child Help, her first group home, had been her best placement. They had animals there and people she could count on. The people who had helped her were the CASA staff.

Mr. Mitry asked if the losses the foster youth had experienced were discussed, in therapy or the group homes, in loving, compassionate ways. Ms. Washington answered that she could discuss those things with certain people with whom she became close.

Mr. Diaz commented from the perspectives of both a social worker and a foster parent: the system is broken. With the heavy caseload, social workers see their clients from a half hour to one hour per month (the requirement). With that amount of time, you cannot make a difference or be supportive for them.

Ms. Watson commented on culture as a big factor – knowing someone who could relate to what the individual is going through.

Ms. Flores expressed concern about re-traumatizing the two youth with the questions.

Ms. Liberato asked if the youth had any hobbies. Ms. Washington replied that she likes to play basketball and box, and she loves law enforcement. She wants to change the criminal justice system. Ms. Morek said that she doesn't really have a hobby, but she does want to change the way people think of law enforcement. She also wants to study criminal justice.

5. Public Comment

A family member (no name given) described her experience with Prop 63 and housing in the Bay Area.

Lyndal-Marie Armstrong, Sonoma County Mental Health Board, stated that she had heard of the new foster care objectives being promoted: to phase out the group home model, and instead use the family experience as best as possible. Has this process begun anywhere? Ms. Flores answered that the person needs to be licensed by one of the three national accrediting agencies. A whole other process occurs after that. Dr. Karen Baylor, Deputy Director of Mental Health and Substance Use Disorders Services at DHCS, said that implementation of the new system is not an event – it will be a process. There is provision for the facilities to prepare.

Ms. Armstrong asked if anyone has begun a local process to communicate among the agencies. Ms. Flores responded that group home certification has started in Santa Clara County – it is truly a reality rather than just a concept.

6. Panel Regarding Outcomes and Support for Youth Exiting Foster Care Including Support Under AB 12

Mr. Orrock stated that AB 12, passed in 2010, allowed for the extension of foster care for youth beyond the age of 18 through 21. He introduced the panel participants.

Hank McKee, TAY Services Director, AB 12 Program with Aspiranet

Tatyanna Washington, foster youth

Carol Sittig, AB 12 Coordinator in San Bernardino County

Lexus Williams, foster youth

Cheryl Placide, AB 12 Program Clinical Supervisor, Department of Behavioral Health

Mr. McKee began. In his program the biggest focus is working with the young adult population aged 18-24. Compared with Florida, California is much more progressive.

Ms. Washington stated that she is a college student who has been in the teen program for a little over a year. She was in foster care since the age of 3, and her aunt became her foster parent when she was 13.

Ms. Sittig is a Child Welfare Services Manager for Children and Family Services. They have a program that includes foster youth and expands to extended foster care services for young adults who have aged out of foster care. Aspiranet is one of the major providers with whom they contract. The program provides housing services, training, workshops, and case management.

Ms. Williams is a former foster child who is now attending Cal State Los Angeles majoring in Criminal Justice.

Ms. Placide is the Clinic Supervisor at one of four Transition Age Youth (TAY) centers in San Bernardino County. They work with minors aged 16-18 as well as 18-25-year-olds. The program stresses relationships and they try to have case managers remain with the youth. They have groups for dealing with stigma, as well as gardening groups that are actually therapeutic.

Mr. Orrock asked the TAY panelists how they had gotten connected to the program.

Ms. Washington said that she had gotten connected to the AB 12 program through her social worker. Ms. Williams had gotten connected through her two social workers and her advocate.

Mr. Orrock asked the panelists to describe the types of programs that are offered post-foster care.

Mr. McKee said that in San Bernardino County, programs include THP-Plus Foster Care for ages 18-21, and THP-Plus. They also have After-Care for young adults who do not need housing but want education, job placement, counseling, and emergency need services which provide a safety net. They also teach basic Life Skills.

Ms. Sittig said that besides the contracted programs with community providers, they have the program with regular continuation of foster care through the county with the Children and Family Services social workers. Foster youth can choose re-entry into the program as long as they are under 21. They also offer various kinds of housing support.

Ms. Placide said that they have a couple of different levels of housing placement. For those with drug and alcohol issues, there is a program. There are licensed board and care homes for youth who may need extra help taking medication. There is an independent living program through Housing and Urban Development.

Mr. Orrock directed the Planning Council to the "California Youth Transitions to Adulthood Study." He asked the panel: *What is working from your perspective? What needs to be better?*

Mr. Diaz stated that the numbers show that the homeless population and young adults in jail are mostly former foster youth. AB 12 helps to prevent that – youth are not turned out on the streets when they turn 18.

Ms. Williams stated that when she turned 18, she tried living on her own but it didn't work at all. The help she is getting now is much better: she has a growth mindset rather than a fixed one. She has a lot of support from her social worker and the county as well as her school, which has an Educational Opportunity Program.

Ms. Washington stated that THP-Plus has been very helpful. It has provided her with an opportunity to go to school and have a job working with kids.

7. Council Questions and Discussion

Ms. Flores commented on the value of THP-Plus and THP-Plus Foster Care to provide youth with the support they need to become who they want to be. She congratulated the two youth panelists.

Mr. Harsch mentioned the Department of Rehabilitation as a resource to pay for college or training for qualified individuals. He also mentioned to Mr. McKee how difficult it is to keep track of the TAY age group once they have an initial evaluation or get a vocational plan written – they may vanish. Mr. McKee shared his frustration: his program is a great opportunity but many youth do not take advantage of it.

Ms. Washington responded, speaking about the difficulty of relating with strangers working in the programs. She suggested having peer support – people who understand each other's backgrounds.

Ms. Sittig added that Parent and Family Services does have a Peer and Family Assistance program consisting of former foster youth who try to help current foster youth – they may be able to relate better.

Ms. Placide commented that texting and emailing is one way to maintain communication. Also, the Peer and Family Advocate program has been very successful.

Mr. McKee noted that in his agency, several staff are former TAY who graduated from the program.

Ms. Williams agreed with Ms. Washington: social workers don't interact with them on a personal level. Advocates can work well.

Mr. O'Neill asked Ms. Placide if her MHSA program has a teen drop-in center. She answered that part of the issue has been recruiting former foster youth soon after they leave the system.

8. Report from Department of Health Care Services

Dr. Karen Baylor, DHCS, provided a report for the Planning Council members.

- The original Bill 403 went through and was about 1,000 pages. DHCS has been working on AB 1997, which has mental health language.
- Colleagues at UCLA told Dr. Baylor's division that they are "the dog that caught the car;" behavioral health has gotten huge attention the last couple of years.

- Regarding CCR: DHCS has a mental health workgroup open to anyone who wants to attend, so the membership is diverse. The workgroup will focus on four main issues:
 - Medical necessity criteria. The Welfare and Institution Code (WIC) lays it out clearly.
 - The role of the Child and Family Team. It is new on the mental health side, having been modeled on the social services wraparound program.
 - The Foster Family Agencies is a totally new entity to county mental health plans. Training on Medi-Cal, billing, documentation, staff for specialty mental health services, etc. all need to be worked out.
 - The Mild to Moderate side is handled through Managed Care.
- A County/State Implementation Committee will continue to have the necessary conversations about any problems that arise.
- There is still quite a bit of tension between the social service side and the mental health side. On the local level each county differs from the next. Everyone wants the same thing: for the kids we serve to have a high quality of life and to get the services they need.
- DHCS hears a lot from the social services side about lack of access to mental health care, but when Dr. Baylor asks in which counties this is happening, the answer is vague. It is a big piece of changing the foster care system with the implementation of CCR. It is a dilemma; Dr. Baylor sought feedback from the Planning Council on this situation.

Questions and Discussion

Dr. Nelson felt that the profession of psychiatry has been struggling with that issue probably longer than DHCS has. The concept of medical necessity is actually not a clinical concept but an insurance concept, designed and developed by the insurance companies as a way to dole out limited resources. Those cases who had the greatest “medical necessity” would receive the most resources. That is the foundation of the conundrum: it is what directs health care delivery systems to provide health care services.

Dr. Nelson continued that insurance companies have always been in the business of providing coverage for either diseases or illness. What if someone is in need of services but is not diseased? This is at the crux of what is going on in the foster care system. That population is at risk of later developing problems that could be diagnosed as serious mental illness. There is no medical necessity, however, for “at risk.”

Some progress has been made recently in that Medicare has agreed to pay for wellness checks; but Medicare and Medi-Cal have two different agendas. One is medical necessity-driven and the other is geared more toward prevention. It is difficult to find a meeting in the middle where the two funding streams can be blended.

Dr. Bennett shared her experience working with a county to integrate children's mental health, juvenile probation, and child welfare data into one system of multidisciplinary case management. During its development, the agencies kept bringing people back to looking at the child and the family instead of the philosophy and the law.

Dr. Bennett felt that the issue starts back in our education systems – the difference in the way mental health professionals, social workers, and probation and law enforcement are trained. A multi-pronged approach is needed to fix the problem.

Ms. Flores said that we need to include group home providers and foster family agencies in the meetings. A component of meetings is training – trying to understand expectations and set up parameters. For example, some group homes are now looking at what accreditation means.

Ms. Mitchell commented that CDSS is the most risk-averse agency she has ever dealt with. Most of the decision-making is based on fear of lawsuits and litigation.

Dr. Pitts suggested for Dr. Baylor's staff to ask for particulars that do not focus on which county, but focus on the story. This would enable them to seek out particular systems of care, who is involved, issues, etc.

Mr. O'Neill agreed that many of us do not understand other systems. Trinity County has been having meetings for about six months with all the players present. The plan has had two drafts; in the second, mental health was mentioned one time as a possible attendee at a foster family meeting. Education was not mentioned at all. There needs to be a lot more dialogue and understanding.

Dr. Baylor gave the example of trauma. From the social services perspective, those who have experienced trauma must have a mental illness and should have specialty mental health services. Another spectrum says that because you have trauma, you do not need to be labeled with a specialty mental health diagnosis.

Dr. Pitts mentioned that the social service system has social workers and the mental health system has social workers. She wondered about the tension within the social work community itself around the DCF social worker and the mental health social worker. She added that the mental health world has made an edict that traumatized people need care. The Social Services side is responding, not seeing themselves as mental health experts. Dr. Baylor agreed, and did not feel that a licensed clinician is needed for trauma if life coaching-type work is what's needed.

Dr. Bennett commented that not all trauma is alike and not all people are alike. We need validated assessments to understand the needs of individual youth and children. Some people who have experienced a traumatic event may not need a clinician or psychiatrist while others certainly do.

Dr. Baylor commented that even the language between social services and mental health – *assessment, certification, outcomes* – has very different meanings.

Mr. Mitry commented that mental health has been respectful and responsive to cultural and linguistic competence. It is very important to push that approach with social

services, especially with our state expanding in diversity. In many ways, reconnecting to a native culture has a healing effect.

Ms. Hart mentioned that Monterey County has a Governance Council comprised of fairly high-ranking representatives from the child-serving departments. They look at a system of care for our children and provide governance for social services reform. They have looked together at both language and data.

Lawrence Gonzaga, Behavioral Health Department for Inland Empire Health Plan, stated that they work closely with Riverside and San Bernardino Counties, as well as DSS and DCF. They have interpreted the most recent All Plan Letter from DHCS to mean that there really aren't tiers in specialty mental health services that apply to the children population. They leave the determination for level of services for a foster youth to DCF in collaboration with DBH. This process that they have developed is seamless.

Ms. Watson felt that it is critically important to bear in mind working with the natural parents in order to limit a child's time in foster care. As a social worker, she has seen that perspectives are different; a system creates its own pinnacles as to what it believes is the best, as opposed to trying to reach resolution and connect with others.

9. Public Comment

Ms. Armstrong noticed in the *California Youth Transitions to Adulthood Study* that one in five of the youth in that study has considered or attempted suicide. Are those rates dropping as this program grows? Dr. Baylor had heard from a report done on suicide hotlines that suicides rates are dropping, but she did not have data in front of her. Ms. Watson added that suicide ideations are not going down, but suicide attempts are. It is an ongoing issue to keep ever present in mind.

10. Council Debrief

Chair Black asked for reactions to the afternoon's panels. Executive Officer Adcock offered for Planning Council members to use this time at the end of the day to ask questions, make statements, and connect the dots.

Ms. Wilson commented that the panels were great. There may be procedural elements to work out: introduce each person, have the moderator ask questions and really moderate, have the Planning Council members be careful about personal questions, and have a reflection right after the panelists leave on what we have learned.

Ms. Wiseman stated that she and Mr. Orrock had prepared a framework for the panelists regarding the information they would present. Panelists had been advised that this was a safe place. Ms. Wiseman had done some follow-up work with the panel following the presentation.

Ms. Flores stated that the idea of a panel gives much real life information that we can use, as well as technical information from the providers. It would have been helpful to develop a template of the type of questions we would want explored. She wanted to make sure that the Planning Council sends thank you notes to all participants. She felt ultra-sensitive to stigma that unintentionally happens when we ask such intrusive questions.

Ms. Wiseman stated that a large portion of what she and Mr. Orrock had done was to interview the panelists. Some of them had asked about the questions they would get, but Ms. Wiseman had no way of telling them. If the staff were to continue with panels in the future, they would need the Planning Council to submit questions beforehand to prepare staff and panelists.

Executive Officer Adcock observed that the focus of the first panel had moved away from Katie A. and into where the two youth were now. The focus had gotten lost.

Dr. Pitts had been very disturbed when the CASA staff had spoken about Ms. Morek's medication history. The foster parent had also given particulars about the child he was caring for. If we are going to bring in experts with experience, we need to review guidelines with them. Ms. Wiseman explained that the youth had public speaking issues and had asked the staff to speak for her. Dr. Pitts felt that the staff should have initially stated, "I have been given permission to speak for..."

Dr. Bennett had also felt uncomfortable. She suggested that if the Planning Council has a small panel, we should not direct our questions to a particular person.

Ms. Liberato felt that the questions the Planning Council had asked were difficult and caused confusion.

Ms. Wilson suggested for the Planning Council members to read the information under the tab in their packets. Also, staff could set up the panel more thoroughly. She agreed with Dr. Bennett that we should only ask general questions. Further, maybe we do not need to ask questions as the panelists speak.

Ms. Lewis felt that the panelists could have been set up a little more – it seemed that they were floundering and didn't know why they were here. Ms. Wiseman responded that she had spoken to the panel several times, and they were advised on the focus of the panel. What Ms. Lewis had seen was the panelists' nerves.

Ms. Lee commented that when she speaks on panels, there is always a facilitator. Having experience makes being a panelist easier.

Ms. Hart suggested that having all of the good background material enabled the panel conversation to move to other topics.

Friday, June 17, 2016

1. Welcome and Introductions

Chair Black welcomed the Planning Council members to the last day of the meeting.

The attendees introduced themselves.

Ms. Prettyman reported Planning Council member Steve Leoni had been hospitalized and was now recovering at home.

2. Opening Remarks

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 (CALBHB/C), reported to the Council.

- CALBHB/C now has an improved Policies and Procedures manual.
- CALBHB/C is in a constant state of flux. It requires the participation of all 25 Directors.
- Dr. Gasco requested that when people bring forth an issue, they also bring a solution.
- On July 1 CALBHB/C enters into the third year of the three-year contract with the Mental Health Services Oversight and Accountability Commission (MHSOAC). Continued funding from them does not look promising. CALBHB/C is trying to clarify that with them and to explore other possible sources of revenue.
- CALBHB/C's Strategic Plan is up for approval by its members. Two columns have been added that establish responsibility, identifying who is responsible for what, and when.

Ms. Hart thanked Dr. Gasco for his service to the organization as his term as President ends. She also thanked the members, including some familiar faces, for their dedication.

Ms. Wilson added that going to the meetings is always a pleasure.

Mr. Mitry asked about the membership of 25 – does that mean that 25 counties are represented and the remainder throughout the state are not? Dr. Gasco replied that the members represent the five state regions: each elects five Directors with three alternates. If funding allowed, Dr. Gasco would jump at the chance to increase participation from each of the regions.

Mr. Mitry noted that in the past, San Mateo County has had CALBHB/C liaisons. Currently, they have not had representation. Mr. Mitry urged the leadership from counties not represented to recruit people to join CALBHB/C.

Dr. Gasco commented that an ongoing challenge is having current contact information from each of the mental health boards. He expressed concern that some of the counties may not be aware that CALBHB/C exists; however, the county mental health boards are mandated by WIC.

Dr. Gasco continued that counties who do not pay their dues are still welcome to attend. CALBHB/C will pay for a representative to attend meetings.

He emphasized CALBHB/C's mission: to support county mental health boards in multiple ways.

Executive Officer Adcock asked if CALBHB/C has an area of focus for the year. Dr. Gasco replied that the three top priorities are funding, funding, and funding past the end of the next fiscal year. The organization is not yet focusing on a programmatic area.

Ms. Wilson noted that she had seen an annual report that CALBHB/C releases every year as a way to connect to every county. Also, every county is a member of CALBHB/C; they pay a fee and get access to information. CALBHB/C raised the fees this year to address the funding problem.

4. Report from CA Behavioral Health Directors Association

Mr. O'Neill, Trinity County Director, reported on the California Behavioral Health Directors Association (CBHDA).

- The CBHDA is fully staffed now, which is very helpful with all that is going on in the Legislature. Kirsten Barlow returned as CEO and is providing very positive and thoughtful leadership.
- Regarding CCR: CBHDA very much supports the idea of reform. However, there are some things in the bill that fly in the face of Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) kind of billing. Nonetheless, the goal is to work with our partners.

One of the confounding issues is that with the foster family agencies providing support in the home, the bill allows for a daily rate that is different from the residential rate – a treatment rate of \$87/day. As claims are uploaded to the state, notes must be written in a way that withstands audits and complies with CMS Title 9's. The bottom line is for youth to get the treatment and reform that they need.

- No Place Like Home is a highly-charged kind of issue. Earlier in June the Planning Council sent a letter to Senator de Leon's office that expressed CBHDA's thoughts perfectly.
- When the CBHDA met in November for strategic planning, they decided their number one goal was housing. As opposed to No Place Like Home, letting each county take 7% and use their local planning process would have been CBHDA's preference. However, the state Senate felt that the money had to be leveraged into the \$2 billion bond and that the process would be competitive.

Because CBHDA is an affiliate of the California State Association of Counties (CSAC), the local behavioral health department is under the authority of the local Board of Supervisors. The CBHDA can never take a position opposing a CSAC position. The best strategy is to work with CSAC, expressing our needs.

As of last Monday night, CSAC had reached an agreement with the Brown administration for a county tier system where at least every county will be competing with counties of the same size.

On Tuesday morning, CBHDA decided to sign on in support with CSAC so that we could have representatives on the advisory committee. This is a bill that the Governor and the Senate want; it is likely going to pass.

- SB 614 Certification for Peer Specialists was sponsored by CBHDA last year. As DHCS is now proposing the bill, they acknowledge that over 6,000 Peer

Specialists are doing important work across the state. The bill should establish support for Medi-Cal billing by Peer Specialists, support skill-building and coaching for beneficiaries with mental health needs, and increase family support, etc.

DHCS is proposing a variation from what stakeholders might want: that Peer Specialists would be equal to Rehabilitation Specialists in reimbursement.

Also in the bill:

- By July 2019, DHCS would establish a certification entity. Renewal would be required every two years.
- Peer Specialists are not qualified to diagnose an illness, prescribe a medication, or provide clinical services.
- MHSAs administrative funds can be used to administer this program.
- There will be a fee for renewing certification.
- If the bill passes, DHCS will negotiate with CMS to ensure that all details are acceptable and counties can actually get reimbursed.

Mr. O'Neill stated that personally he is a firm supporter of Peer Specialists. This bill may not be everything that everybody wants, but he would hate to see the legislative year end without having something to show for it. The bill's actual title is the "Medi-Cal Specialty Mental Health Services Specialists Act."

Last week CBHDA agreed to go back to stakeholders and the California Association of Mental Health Peer-Run Organizations (CAMHPRO) to see what they think about it.

Questions and Discussion

Ms. Mitchell reported that she had just received an email that No Place Like Home did not pass the Senate (it needed a two-thirds majority). It goes back to a Senate vote on Monday. If it does not pass then, it will return during July or August.

Ms. Mitchell's personal view was that it needed a lot more work to make it palatable. There was no hurry to pass it because it was not part of the State Budget. Even though it is in a trailer bill, it is really an amendment to the MHSAs.

Ms. Mitchell asked if the Peer Specialist federal payment rate would be the same as for mental health services, or if the wage rate will be the same as for clinicians? Mr. O'Neill answered that the reimbursement rate from the federal government would be the same as for clinicians. Each county would have to decide on the wage for Peer Specialists.

5. Report from Mental Health Services Oversight and Accountability Commission Re: Children's Crisis Report

Sheridan Merritt, Research Program Specialist, MHSOAC, discussed Children's Crisis Services: experiences, lessons learned, and future directions.

This type of project is a new direction for the MHSOAC – they are identifying specific areas and delving deeply into them, then making specific recommendations to go to the Governor’s Office, Legislature, advocacy groups, and DHCS.

The project started from a story of a suicidal nine-year-old girl. She spent three days in the hospital Emergency Department, without any treatment or services, waiting to be transported to a psychiatric facility. She was transported from L.A. to a bed that became available in San Francisco, then released after a few days back to her family without any linkage or supports. This was not an isolated case; children are spending days or weeks in the Emergency Department waiting for some kind of intervention.

MHSOAC Commissioner Boyd led the project, which developed as follows.

- Identify an advisory group of experts in the field: providers, parents, youth, advocates, state agencies.
- At two MHSOAC meetings the Commissioners focused specifically on children’s crisis services. They met with facilities and mobile crisis providers.
- They had a series of panel presentations with advocates, parents, youth, and an ER doctor.
- They gained a greater understanding of the issues and challenges, and brought the Commissioners along in the process.
- They looked at the models in California communities and other states.

The scope of the problem is such that 15% of high school students have seriously considered suicide in the last 12 months. 8% have attempted it.

Five out of every 1,000 children of ages 5-19 were hospitalized for a mental health issue in 2014. There were more than 23,000 involuntary 72-hour detentions.

Only 14 counties in the state have acute care facilities for children and youth. The situation seems to be getting worse instead of better over the last few years. The hospitalization rate for children of ages 5-14 has increased 60% since 2007. The lack of available community care is creating a bottleneck in emergency rooms.

In other models, once a child is known to the system, all the people involved in the child’s life are working collaboratively, coordinating their efforts. Families learn safety planning – identifying triggers, learning what works and doesn’t work, finding natural family and peer supports. A few states use the 211 crisis line. In Massachusetts, a mobile crisis worker responds to anywhere within the state within an hour.

In California we do not have the continuum where, as the crisis unfolds, you can ratchet up the level of services and intervention based on the needs of the child and family – gradually moving them back down as the situation resolves.

In California there is no inventory of what is available in different counties.

Many of the children have multiple surrogate agencies in their lives: foster, juvenile, justice, schools, etc. Each has its own mission, funding restrictions, regulations, and there is generally a lack of coordination between them.

Under the current reimbursement structure, it is very hard to provide alternatives to hospitalization such as crisis stabilization units – for Medi-Cal the costs just don't cover the expense.

Private insurance has a major role to play; they are somewhat late to the game. They are required to provide medically necessary care for behavioral health/mental health conditions; that should include mobile services and home-based services, whether in the public system or the private system. Many private carriers are now starting to recognize potential cost savings if they can work with the children and families in their communities rather than going to the ER. They can save money and have better outcomes.

Rural communities have challenges in terms of distances. Lack of threshold language is another challenge, as is data-sharing.

In this area there is tremendous opportunity for cost savings. The cost for one acute episode can quickly mount up to \$20,000. Home-based, mobile services in a community potentially provide a much better outcome for much less money.

Questions and Discussion

Mr. Schroeder asked what is driving the marked increase in hospitalization rates. Mr. Merritt replied that there are many theories. With social media comes increased bullying, and community-based services are reduced due to the 2008 recession. In the absence of other alternatives people know that ERs are open 24/7.

Dr. Mueller commented that we know peer support is of great value. Would Mr. Merritt consider putting on the list, support for groups using social media? Mr. Merritt agreed; organizations are now providing texting as an option for communication. There is also a safety planning phone app where you can put in contact information, significant people for you, preferences for a crisis situation, etc.

Ms. Prettyman said that there used to be crisis residential centers for adolescents. Mr. Merritt responded that legislation going through now, AB 741 would allow counties to get licensed for such facilities and then reimbursed.

Ms. Watson asked if the MHSOAC or some agency would take on identification of each county's services and gaps. Servicing kids closer to home is the important piece of what should happen. She also asked about exploring psychiatric urgent care models for providing a continuum of care. Mr. Merritt replied that it is a central piece. L.A. County has been a trendsetter in the area of urgent behavioral health care centers. The project's first finding was that there are too many kids in California who are not getting the type of crisis services they need, but are legally mandated under federal law to receive – and it is the right thing to do. The first step is working with state partners – DHCS and the Department of Managed Health Care – to define clearly the minimum standards. We need to identify the counties that do not meet them, and work with them to fill that gap: with new, expanded MHSOAC money or new triage funding.

Ms. Watson emphasized that if a child needs to be transported out of the community or county because of a lack of services, that is a failure of the system to serve the child. Mr.

Merritt agreed, stating that for many of these kids, a crisis event like this is their first introduction to mental health services. If it goes horribly wrong, the child and family will not likely seek services again.

Mr. Schroeder commented on the private insurers: they understand neither their role nor the California parity law to provide all necessary treatment for children with SUDs. There is work to be done with the insurers and the Department of Managed Health Care to get them to understand what the law means. Mr. Merritt agreed.

Mr. O'Neill commented that at Round 5 of the California Health Facility Finance Authority (CHFFA) there were some projects specific to children mobile crisis. If there is remaining funding in SB 82, they would like to do a round for children. He stated that sending a child to an inpatient bed is the last thing we want to do – he totally supported alternatives. Mr. Merritt agreed that we need to do everything in our power to keep the child within the community and the family working through the crisis.

6. Executive Officer's Report

Executive Officer Adcock reported on the following.

- A new staff member will be joining the team.
- During the summer, staff will be working on drafting the reports with the information that the Planning Council has been reviewing during the last five meetings. Final approval will be in January.
- Staff has been working on the No Place Like Home bill and SB 614. They forwarded the CMHPC letter about No Place Like Home to the Governor's Office, reminding him that we are his advisory body per state law.
- Executive Officer Adcock and Ms. Shaw presented at the Little Hoover Commission hearing on the MHSA on May 26. Planning Council members received a copy of the full written commentary and the oral testimony.
- The Mental Health Matters Day on May 24 was a huge success. Its development was headed up by Mental Health America California; many organizations including the CMHPC helped. Assembly Member Rocky Chavez delivered the opening remarks.

Questions and Discussion

Mr. Blackford asked about the new staff member's duties. Executive Officer Adcock replied that we have had a vacancy to support the Patient Rights Committee. The new staff member will also be performing other projects – initially he will collaborate with Mr. Orrock on the Workforce Ad Hoc Committee.

7. 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 has a single project: to research and explore areas around the Patients' Rights Advocates' responsibilities, and to decide whether there should be discussion regarding the ratio of Patients' Rights Advocates with the community.
- Another issue is that since the law came out requiring Patient Advocates, there have been many changes in the provision of mental health services. There may be other avenues in which advocacy needs to be done.
- Attending the committee meeting was Jim Preis, Executive Director of the Mental Health Advocacy Services, Inc. in L.A. County. He is a member of the California Association of Mental Health Patients' Rights Advocates (CAMHPRA). The committee has been able to connect with that organization. Ms. Shaw and Mr. Orrock participated in a meeting with them via conference call; following the discussion, CAMHPRA created a task force to look at the issues that the Patients' Rights Committee has been concerned about.
- The committee has been concerned that Patients' Rights Advocates spend a great percentage of their time representing clients at certification hearings, rather than performing duties that have to do with quality of life issues for clients when they have been involuntarily held.
- Mr. Preis spoke about the concept of *therapeutic jurisprudence*: the study of how legal systems affect the emotions, behaviors, and mental health of people.

Questions and Discussion

Dr. Petties asked about the study that was done on mental health ratios. Ms. Shaw replied that it was done in 1986 and listed responsibilities; it recommended a ratio of 1 to 300,000.

Health Care Integration Committee

Committee Chair Terry Lewis reported on the following.

- Most of the meeting focused on the relevance of its charter and alignment of the charter with the work plan. The conversation extended to the need to look at orientation in terms of health care integration. The committee removed the word *reform* because we are no longer reforming the system. The committee added new definitions that pertain to the broader picture. With five new members, the committee looked at the opportunity to do mentoring earlier for them.
- The committee had the target of looking at health plans for mild to moderate health needs – data on utilization and hospitalization rates. They partnered with Catherine Teare of the California Health Care Foundation, who has hired a consultant to put this part of the work together. The draft will arrive next week, and by October the committee hopes to have what it needs.

Continuous System Improvement Committee

Committee Chair Lorraine Flores reported on the following.

- The Data Notebook is running a little behind – the issue is getting data from DHCS. It has the same theme as the Planning Council: Children and Youth.
- The committee discussed LGBTQ issues. Mr. Orrock and Ms. Flores will be working on a white paper; they will come up with some recommendations, but not duplicate what is already out there. They would like to review the general recommendations for LGBTQ services. Clearly, more data is needed related to the number of LGBTQ youth out there, and the number that seek mental health services versus the number that don't. Ms. Flores and Mr. Orrock also want to cover homelessness, suicide rate, and health inequities.

Ms. Flores sought ideas and recommendations from the rest of the Planning Council.

Questions and Discussion

Chair Black asked if they will be addressing geographical variation in the white paper. Ms. Flores said that they would certainly take a look. The biggest issue is the lack of data available from county to county.

Advocacy Committee

Committee Chair Darlene Prettyman reported on the following.

- The committee had a lively discussion on No Place Like Home. They reviewed their letter on this topic.
- *Goal 1: Logistical, fiscal, and programmatic efforts to transition people out of IMDs.* They received information from DHCS but did not feel that it represented what was truly happening. The committee has invited DHCS to send someone to explain the document and its figures.

In the meantime, staff will be writing to Sacramento and Riverside Counties to check the data.

- *Goal 2: Closures of residential care facilities in California.* The committee members will contact their respective Mental Health Directors with a survey that Ms. Wiseman will prepare. The committee will then follow up with a conference call, and prepare a draft report to present in October.
- *Goal 3: Follow up on the implementation of AB 109.* The committee has the necessary information to present to the Planning Council in January.
- *Goal 4 (the newest goal): Prevention and wellness strategies for at-risk juveniles in the criminal justice system.* The committee is in the process of gathering information for their report for the Planning Council.
- The committee had a long discussion on legislation. Ms. Prettyman noted that the CMHPC is not a part of the No Place Like Home Advisory Committee as requested; we should continue to work on that. The committee opposed AB 1300, AB 876, and AB 2017. They are watching SB 1273 and AB 2005.

Questions and Discussion

Dr. Pitts commented on Goal 1: there are several states that have had to enter into consent decrees as a result of failing to meet the Olmstead Law. They have been forced to invest in programs and services to move people out of nursing homes into community living. More states are being sued by advocates to move people out of long-term treatment settings and inappropriate placements – nursing homes in particular.

The group discussed data showing that people are going into Skilled Nursing Facilities, even the locked units there.

Executive Officer Adcock requested the Planning Council members to make suggestions on better ways that staff can keep them informed without inundating their inboxes.

8. Public Comment

There were no comments from the public.

9. Planning Council Behavioral Health Integration Strategic Plan Framework Discussion

Executive Officer Adcock gave an update on various integration activities.

Regarding statute changes: CMHPC submitted revised WIC sections to the Senate Committee on Health, but a Republican consultant opposed the move. A new legislative cycle will start in January. Executive Officer Adcock asked the Planning Council members to talk with their legislators about the need to put CMHPC statutory changes perhaps in a mental health-related bill.

Until these changes in law occur, the CMHPC cannot be very assertive about advocacy on substance abuse. We can continue our knowledge-building and strategic planning.

Dr. Baylor stated that she shared the frustration about DHCS and data. The modernized computer CSI data system is close to getting into the DHCS warehouse.

DHCS has posted a paper on integration on its website. They have found a model they like for California. The integration of mental health and substance use disorders is very important; most of the counties are behavioral health counties. All of that has to be integrated into physical health care, and it needs to go both ways.

The Substance Abuse & Mental Health Services Administration (SAMHSA) model is on a continuum from no integration at all to full integration – a good framework with which to start.

DHCS is going to focus on two main areas in its integration work: health information exchange and payment reform.

Dr. Baylor requested the Planning Council to look at the current document on its website – which shows the work DHCS is required to do – to see if there is any intersection with the work the CMHPC members are doing, and to give feedback.

Executive Officer Adcock stated that the Steering Committee thought it would be helpful in this meeting to hear from two CMHPC members who are substance use providers in rural areas.

Ms. Susan Wilson spoke about Shasta County. On the “frontier” there are two issues of note: lack of resources and the workforce issue. She runs a substance use disorder treatment program that is a private non-profit.

- They have braided funding: Medi-Cal, the local hospital, the Health and Human Services Agency, and the schools (they also serve adolescents).
- The program provides outpatient drug-free services – individual and group counseling for both adults and youth. They provide medication-assisted therapy supervised by a local physician in the clinic once a week. They provide transport to the clinic because there is no public transportation.
- There is an issue of compensation for case management. They get paid to do therapy but not for all the extra work that is non-crisis related.
- They partner with the Women’s Health Specialists, the Positive Parenting Program, and the high school (particularly alcohol issues).

Dr. Baylor said that to take the Substance Use delivery system (pretty minimal in California) and develop a continuum of care treatment is very exciting. California is leading the nation in this effort, and everyone is watching us. DHCS is rolling the program out in phases; the Bay Area was first. Phase 5 will be the tribal communities.

Ms. Susan Wilson said that to address whole person care, Shasta County has built a partnership with a federally qualified health center that is not too far away.

Dr. Bennett asked if certification processes are going to be different under the Waiver. Dr. Baylor replied that because of one provider’s fraudulent activity, all the SUD providers had to go through the DHCS Provider Enrollment Division. The backlog is now gone. The process will soon be digitized for providers to complete online.

Mr. O’Neill spoke about the Drug Medi-Cal program in Trinity County. They decided to become Medi-Cal-certified so that in addition to SAMHSA grant dollars, they could also receive Drug Medi-Cal dollars.

In January 2017, all the rural northern counties will have the option of being able to opt in to the organized delivery system, which expands the kinds of reimbursements counties can receive for services: for instance, residential treatment, medical detox, and intensive outpatient services. Counties will need to submit a plan to DHCS.

In those counties, Partnership Health is a Medi-Cal physical health managed care plan. That provider recognizes that they will realize a tremendous cost savings if, on the physical health side, their consumers are getting the SUD treatment they need. Partnership Health is interested in cooperating and being a partner in a regional model where eight counties combine and submit one plan for an organized delivery system. Mr. O’Neill felt that this arrangement will make more services and more funding available, even though Trinity County will give up some autonomy.

Mr. Mitry asked about transportation to other counties for services. Mr. O’Neill answered that Partnership Health is willing to reimburse for transportation. He agreed with Mr. Mitry that family always need to be involved in permanent solutions.

Ms. Wilson commented that in some ways the SUD treatment system hit the issues of recovery before the mental health system did. They use a lot of Peer Specialists. Every employee working for her has lived experience; they also love to include families. One of the problems with SUD services is 42CFR; they have a firewall around exchange of information.

10. Closing

Chair Black requested for the Planning Council to adjourn in memory of those who had lost their lives, and the families and friends who remain, in Orlando and San Bernardino.

11. ADJOURN

Chair Black adjourned the meeting at 11:48 a.m.

C TAB SECTION

DATE OF MEETING 10/20/2016

MATERIAL
PREPARED BY: Wiseman

DATE MATERIAL
PREPARED 9/15/2016

AGENDA ITEM:	California Consortium of Addiction Programs and Professionals (CCAPP)
ENCLOSURES:	

BACKGROUND/DESCRIPTION:

Continuing the expansion of the Council's knowledge of the Substance Use Disorders treatment and delivery system, this presentation covers the various types and requirements of licensed/certified providers for SUD treatment in California as well as current workforce issues. This will add the SUD workforce to the Council's existing knowledge base of mental health providers, their requirements, role in service delivery and shortages.

Presenters:

Pete Nielsen, Chief Executive Officer
Sherry Daley, Senior Governmental Affairs Director

Company synopsis:

CCAPP is the largest statewide consortium of community-based for profit and non-profit substance use disorder treatment agencies and addiction-focused professionals, providing services to over 100,000 California residents annually in residential, outpatient, and private practice settings.

The Planning Council is continuing in its efforts to gain information, insight and perspective of those experiencing substance use disorders. The California Consortium of Addiction Programs and Professionals will present information about their organization's history, their successes and share any workforce concerns they may have experienced when staffing programs to serve those with substance use disorders.

CCAPP website can be found at: <https://www.ccapp.us>

MATERIAL
PREPARED BY: Wiseman

DATE MATERIAL
PREPARED 9/19/2016

AGENDA ITEM:	Adult Residential Care for Substance Use Disorders (SUD)
ENCLOSURES:	Background Information for WellSpace Health and Turning Point Community Programs

BACKGROUND/DESCRIPTION:

This presentation will provide Council members with information regarding residential treatment services for SUD and co-occurring mental health and SUD disorders.

WellSpace Health (formerly known as The Effort) offers a full continuum of substance abuse and co-occurring disorders treatment. Integration of addiction services with primary care and mental health opens up a new door in treating the whole person and addresses secondary issues complicating or preventing a full recovery.

Integrated SUD programs, including:

- Inpatient
- Medically Monitored Detox
- Group Counseling, Parenting Classes, and Evaluations
- Outpatient
- Individual
- Adult Drug Court: Addiction & Co-occurring
- Medical and Behavioral Health Interventions
- Employee Assistance Programs

Turning Point Community Programs (TPCP) has a history of providing treatment and services to adults with psychiatric disabilities. TPCP is projected to open two Adult Residential Treatment programs focused on adults with co-occurring mental health and

SUD disorders. Al Rowlett, Diana White and Leslie Springer will present to the Council about Turning Point's history and insight in the efforts to open up the two new Co-Occurring Residential Treatment programs in Sacramento County.

TPCP also provides services in Merced, Solano, Yolo, Butte, Placer, Stanislaus and Nevada counties.

Turning Point's website can be found at <http://www.tpcp.org/home>

DRAFT

FACT SHEET

Drug Medi-Cal Organized Delivery System Waiver



The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder (SUD). According to the National Survey on Drug Use and Health, 2008-2011, nearly 12 percent of Medicaid beneficiaries over 18 have a SUD. Of the individuals that previously did not have Medicaid benefits but now qualify due to the expansion of services, 13.6 percent have a SUD. The DMC-ODS will demonstrate how organized SUD care increases the success of DMC beneficiaries while decreasing other system health care costs. The Waiver will make improvements to the Drug Medi-Cal service delivery system by focusing on critical elements of the DMC-ODS pilot which:

- Provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services;
- Increases local control and accountability with greater administrative oversight;
- Creates utilization controls to improve care and efficient use of resources;
- Increases program oversight and integrity;
- Provides more intensive services for the criminal justice population which are harder to treat;
- Requires evidence based practices in substance abuse treatment; and
- Increases coordination with other systems of care including physical and mental health.

This approach is expected to provide the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery.

Continuum of Services Provided

Counties that opt-in to participate in the DMC-ODS are required to provide a continuum of services to all eligible beneficiaries modeled after The ASAM Criteria. Services required to participate in the DMC-ODS include:

- Early Intervention (overseen through the managed care system)
- Outpatient Services
- Intensive Outpatient Services
- Short-Term Residential Services (up to 90 days with no facility bed limit)
- Withdrawal Management
- Opioid/Narcotic Treatment Program Services
- Recovery Services
- Case Management
- Physician Consultation

FACT SHEET

Drug Medi-Cal Organized Delivery System Waiver

The following *optional* services can also be provided to beneficiaries by counties:

- Additional Medication Assisted Treatment (MAT)
- Partial Hospitalization
- Recovery Residences

Implementation Plan Schedule

County participation in the Waiver is voluntary. Opt-In Counties are required to submit a county implementation plan to DHCS. Plans will be reviewed and approved by DHCS and CMS. Fifty-three (53) counties expressed interest in participating in the Waiver as of January 2015.

1. Phase One: Bay Area (June -September 2015)
2. Phase Two: Southern California
3. Phase Three: Central California
4. Phase Four: Northern California
5. Phase Five: Tribal Partners

Quality Improvement

Counties shall have a Quality Improvement Plan and Quality Improvement Committee, as well as shall provide data to evaluate outcomes from the Waiver related to access, quality, cost and integration and coordination of care.

Access and Utilization Management

Counties shall have a toll free access line and shall authorize Residential services. Counties shall also have a Utilization Management Program that assures access to services; assures medical necessity has been established and the beneficiary is at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care.

Fiscal

Rates are set at the State rates; however, counties can propose coming in higher or lower except for Narcotic Treatment Program (NTP) services. The State will negotiate the proposed rates with the counties and will have final approval. DHCS will continue to set the rate for NTP services.

Evaluation

The University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care.

For Additional Information Regarding the DMC-ODS

- Visit <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>
- Contact Marlies Perez at Marlies.Perez@dhcs.ca.gov

California Mental Health Council
 Brief Overview of the
 Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver
 October 2016

The California Department of Health Care Services (DHCS) has received 1115b waiver approval from the federal government to implement the expanded substance use treatment options for individuals with Medicaid eligibility. The program is called the Drug Medi-Cal Organized Delivery System (DMC-ODS).

The following charts were obtained from the DHCS “*Starting Blocks, Insights from Phase I Counties*” by Paula Wilhelm¹ and the “*California Bridge to Health Reform Drug Medi-Cal Organized Delivery System Waiver Standard Terms and Conditions (STCs), August 6, 2015*”².

The charts are being provided for informational purposes to assist in illustrating the type of services now available to Medi-Cal beneficiaries under the DMC-ODS waiver. Each of the three (3) charts has a title which correlates to the groupings of the services presented in the chart.

Continuum of Care Services

Title	Description	Provider
Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Managed care or fee-for-service provider
Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities
Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	DHCS Certified Intensive Outpatient Facilities
Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated Residential Providers

¹ [Link to "Starting Blocks, Insights from Phase I Counties"](#)

² [Link to "California Bridge to Health Reform Drug Medi-Cal Organized Delivery System"](#)

California Mental Health Council

Brief Overview of the
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver
October 2016

Title	Description	Provider
Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated Residential Providers
Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community	DHCS Licensed and DHCS/ASAM Designated Residential Providers
Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals
Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals, Hospital; Free Standing Psychiatric hospitals
Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed OTP Maintenance Providers, licensed prescriber

Withdrawal Services (Detoxification/Withdrawal Management)

Level of Withdrawal Management	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, licensed prescriber; or OTP for opioids.
Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; licensed prescriber; or OTP.
Clinically managed residential withdrawal management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification; Physician, licensed prescriber; ability to promptly receive step-downs from acute level 4.

California Mental Health Council

Brief Overview of the
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver
October 2016

Level of Withdrawal Management	Description	Provider
Medically monitored inpatient withdrawal management	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Hospital, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals; ability to promptly receive step-downs from acute level 4
Medically managed intensive inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Hospital, sometimes ICU, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals

Required and Optional DMC-ODS Services

Service	Required	Optional
Early Intervention	<ul style="list-style-type: none"> • (Provided and funded through FFS/managed care) 	
Outpatient Services	<ul style="list-style-type: none"> • Outpatient (includes oral naltrexone) • Intensive Outpatient 	<ul style="list-style-type: none"> • Partial Hospitalization
Residential	<ul style="list-style-type: none"> • At least one ASAM level of service initially • All ASAM levels (3.1, 3.3, 3.5) within three years • Coordination with ASAM Levels 3.7 and 4.0 (provided and funded through FFS/managed care) 	<ul style="list-style-type: none"> • Additional levels
NTP	<ul style="list-style-type: none"> • Required (includes buprenorphine, naloxone, disulfiram) 	
Withdrawal Management	<ul style="list-style-type: none"> • At least one level of service 	<ul style="list-style-type: none"> • Additional levels
Additional Medication Assisted Treatment		<ul style="list-style-type: none"> • Optional
Recovery Services	<ul style="list-style-type: none"> • Required 	
Case Management	<ul style="list-style-type: none"> • Required 	
Physician Consultation	<ul style="list-style-type: none"> • Required 	

California Mental Health Council
 Brief Overview of the
 Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver
 October 2016

The items contained within the “DMC State Plan” column are services currently provided prior to the implementation of the 1115 Waiver. The items contained within the “DMC-ODS: Opt-In” column are to be included in the new Organized Delivery System within Drug Medi-Cal.

Evidence-Based Continuum of Care

DMC State Plan	DMC-ODS: Opt-In
Outpatient Drug Free Treatment	Outpatient Services
Intensive Outpatient Treatment	Intensive Outpatient Services
Naltrexone Treatment (oral for opioid dependence or with treatment authorization for other)	Naltrexone Treatment (oral for opioid dependence or with treatment authorization for other)
Narcotic Treatment Program	Narcotic Treatment Program
Perinatal Residential SUD Services (IMD exclusion)	Residential Services (not restricted by IMD exclusion or limited to perinatal)
Detoxification in a Hospital (with treatment authorization)	Withdrawal Management
	Recovery Services
	Case Management
	Physician Consultation
	√ Partial Hospitalization (optional)
	√ Additional Medication Assisted Treatment (optional)

The table above was adapted in part from a graphic by Harbage Consulting: “CHCF Legislative Staff Briefing on DMC-ODS Pilot Program,” Harbage Consulting, (Sacramento, CA: Presentation to California Legislative Staff, December 2015).

WellSpace Health

History

WellSpace Health is the result of a merger between two Sacramento social service agencies. Family Service Agency historically provided child and family therapy, crisis intervention, and violence prevention. WellSpace Health provided primary health services and treatment of substance abuse. On October 1, 2005 these two agencies merged to create Sacramento's single largest provider offering a full continuum of care for health, mental health, and addictions treatment.

Mission Statement

Achieving regional health through high quality comprehensive care.

Federally Qualified Health Center

WellSpace Health has served Sacramento's low-income and underserved individuals and families since 1953. In 2005, after feedback from clients and the community, the organizations changed its 30-year-old Free Clinic license to a Community Clinic status and began the process of applying to be a Federally Qualified Health Center (FQHC). Preliminary *'look alike'* approval of the FQHC designation was received in 2008, and final approval as a *'full'* FQHC was received in 2009. WellSpace Health is the only *'full'* FQHC serving the Sacramento region.

As an FQHC, WellSpace Health is able to bill the federal government for supplemental funding for health, behavioral health (e.g. specialty psychiatry, therapy), children's dental, and other services. This provides a critical health access point for underserved persons in the community, and leverages federal funding while state and local funds are shrinking.

WellSpace Health has built a network of primary care clinics that provide a *'synergy'* of services, with our doctors treating the whole person with a treatment model called Integrated Behavioral Health. (Including counseling, alcohol and drug addiction treatment and appropriate therapy. WellSpace Health is a statewide leader in designing and delivering Integrated Behavioral Health.

WellSpace Health accepts some medical insurances such as Medi-Cal, Medicare and Blue Cross.

Since 1968, WellSpace Health has also operated the Suicide Prevention Crisis Line, We are the regional provider of suicide prevention for 32 counties in Northern and Central California. We answer calls 24 hours a day, 365 days a year from those living within the 916, 209, 530, and 707 area codes.

Contact Information: telephone: **916-737-5555**, Email: info@wellspacehealth.org



Crisis Residential Services

CRP PROGRAM DESCRIPTION

The Crisis Residential Programs (CRP) provide treatment for adults with psychiatric disabilities who have become suicidal, critically depressed, or otherwise psychiatrically in need. With constant review, discussion, and negotiation, members and staff continually refine this program. The services provided at this home routinely avert the need for hospitalization with the integration of values to include member input and peer support, program flexibility, mutual trust, and working together.

SERVICES PROVIDED

CRP services are designed to resolve the immediate crisis and improve the functioning level of the individuals to allow them to return to less intensive community living as soon as possible. To reach this goal we will be providing the following services:

- Psychosocial and risk assessment
- Psychiatric assessment
- Nursing assessment
- Individualized treatment planning
- Individual and group counseling
- Linkages to community supports
- Social and recreational activities
- Discharge planning and referral sources
- Education on mental health and co-occurring diagnoses
- Self-help support systems
- Peer-to-peer mentoring
- Relapse prevention skills
- Basic skills for everyday living

PROJECTED OUTCOMES

- Reduced average time for visits to emergency rooms of local hospitals.
- Reduced hospital emergency room and psychiatric inpatient utilization.
- Reduced law enforcement involvement on mental health crisis calls.
- Improvements in participation rates by consumers in outpatient mental health services and case management services.
- Consumer's and/or family member's, when appropriate, satisfaction with crisis services the consumer received.

CURRENT CRISIS RESIDENTIAL PROGRAMS

Sacramento CRP

4801 34th St.,
Sacramento, CA 95820

Program Start Date: June 1992



Bender Court CRP

6825 Bender Court,
Sacramento, CA 95820

Program Start Date: February 2014



Rio Linda CRP

505 M St.,
Rio Linda, CA 95673

Program Start Date: June 2016



COMING SOON

Co-Occurring Disorders CRP - 7415 Henrietta Drive, Sacramento, CA 95662

Projected Grand Opening: December 2016

The Co-Occurring Disorders CRP will focus on diversion from EDs with an emphasis on individuals experiencing an immediate mental health crisis who have a co-occurring substance use disorder. While primary focus will be diversion from emergency departments (ED), there will also be some capacity for community provider referrals to prevent inappropriate and unnecessary psychiatric hospitalizations or ED visits. The goal is to receive the referral, interview the client and admit the individual to the crisis residential program within the same day.

Rapid Turnaround Step-Down CRP - 9048 Elm Avenue, Orangevale, CA 95662

Projected Grand Opening: June 2017

The Rapid Turnaround Step-Down Crisis Residential Program is a short-term program model that will focus on diversion from emergency departments (ED). Beginning with an in-depth clinical assessment and development of an individualized service plan, staff will work with consumers to identify achievable goals including a crisis plan and a Wellness Recovery Action Plan (WRAP). The goal for this program is to receive the referral, interview the client while in the emergency department and admit the individual to the crisis residential program within the same day.



TURNING POINT
COMMUNITY PROGRAMS
A Path to Mental Health

CRISIS RESIDENTIAL PROGRAM

4801 34th Street, Sacramento, CA 95820

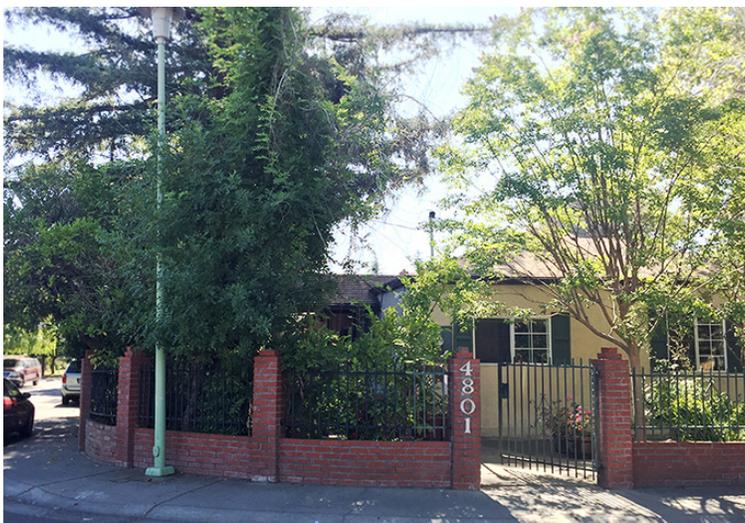
(July 2014 - June 2015)

PROGRAM DESCRIPTION

Crisis Residential Program (CRP) provides treatment for adults with psychiatric disabilities who have become suicidal, critically depressed, or otherwise psychiatrically in need. With constant review, discussion, and negotiation, members and staff continually refine this program. The services provided at this home routinely avert the need for hospitalization with the integration of values to include member input and peer support, program flexibility, mutual trust, and working together.

“This is the first time I came or participated in a program. I lost everything: my home, my job, my family, my sobriety, my mental health. Crisis Res and staff brought me back to gain confidence and find my grounding to believe in myself to accept that I am an alcoholic and that I have a mental health condition. I have learned how to live with it and manage it. I am not ashamed of it or controlled by it. I am now able to move forward with my life. Thank you.”

- CRP service recipient



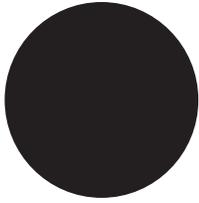
Within the 14/15 Fiscal Year, CRP..

**Respondents to follow-up survey*

- Has served 149 individuals
- Served 10 or more individuals for 69.0% of the year (or 252 days)
- Had an overall satisfaction rate of 87.0%
- Discharged 66.0% of clients because he/she successfully met his/her goals
- [Between admission and discharge] Decreased homelessness by 46.8%

AVERAGE COSTS PER CLIENT (PER DAY/STAY)

*Cost per Client based on 13-14 FY data



CRP Cost per Client
Average \$17.13 per day (365 days/year)



Incarceration¹
Average of \$83.53



Psychiatric Hospitalization²
Average Cost per Stay \$5,700 (National Avg. Stay = 8 days)

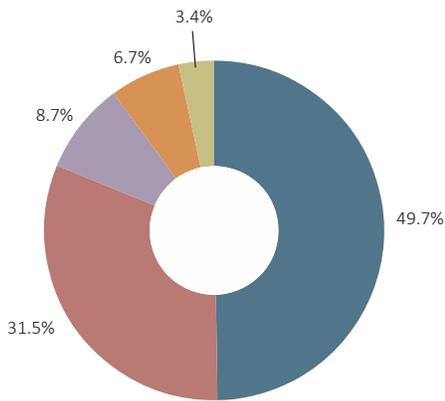


Societal Cost of Homelessness³
Between \$95.89 and \$410.96 (Average about \$253.43)

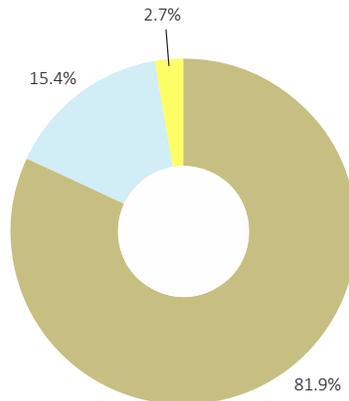


Emergency Room^{4,5}
Average \$415.00 per visit (based on L.A. data)

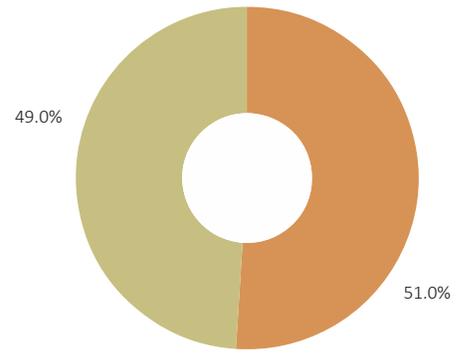
CLIENT DEMOGRAPHICS



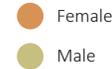
Race



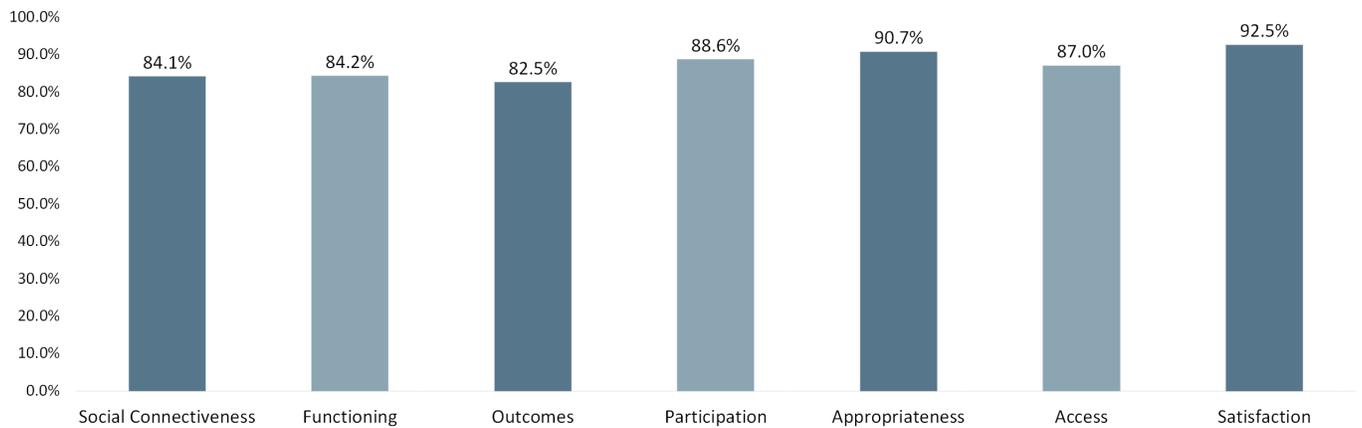
Age Group



Gender



CONSUMER SATISFACTION



TPCP / 3440 Viking Drive, Suite 114, Sacramento, CA 95817 / (916) 364-8395 / www.tpcp.org

¹ United Way of Greater Los Angeles. (2009). *Homeless cost study: United Way of greater Los Angeles*. Los Angeles, California: United Way of Greater Los Angeles.

² Piper, K. (2011). Hospitalizations for mental health and substance abuse disorders: Costs, length of stay, patient mix, and payor mix. Retrieved April 3, 2015, from <http://www.piperreport.com/blog/2011/06/25/hospitalizations-for-mental-health-and-substance-abuse-disorders-costs-length-of-stay-patient-mix-and-payor-mix/>.

³ Giovannetone, A. S. (2014). *Here's a solution for homelessness that works*. Retrieved April 3, 2015, from <http://www.sacbee.com/opinion/op-ed/soapbox/article3421894.html>.

⁴ Sacramento County Sheriff's Department: Main Jail Division. (2014). *Tour information brochure* [Brochure]. Sacramento, California: Sacramento County Sheriff's Department.

⁵ Leury, M. (2013, November 7). *Is prison realignment working in California?* Retrieved April 3, 2015, from <http://www.kcra.com/news/is-prison-realignment-working-in-california/22858802>.

E TAB SECTION

DATE OF MEETING 10/19/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 9/17/16

AGENDA ITEM:	Volunteers for Nominating Committee
ENCLOSURES:	

General Overview

The Nominating Committee is made up of one representative from each appointment category. The Nominating Committee’s task is to propose a Chair-Elect since the previous year’s Chair-Elect is already in line to become the Chairperson in January. After reviewing all the guidelines and background information, the committee generates names of members who are perceived to have leadership qualities.

The committee then discusses the names that have been generated, evaluating them according to a number of criteria, such as leadership potential and appointment category, and ranks the names in order of preference. The next step is to contact the potential candidate to see if he or she will accept the nomination. Usually the Nom Cmte Chair makes the calls unless other members of the committee have a closer relationship with the person in question. If the first choice should decline, then we move down the list.

Operating Policies and Procedures

I have enclosed an excerpt from the Operating Policies and Procedures that outlines the adopted policies regarding the responsibilities of the Chairperson and Chair-Elect and the selection criteria for the Chair-Elect.

Criteria for Chair-Elect:

- ◆ It is recommended that a nominee have served as a chair, vice-chair, or alternate chair of a committee or subcommittee for at least one year.
- ◆ Job Description for Chairperson is enclosed. It describes the skills that the Chairperson must possess.
- ◆ Because the Chair-Elect basically has a year of training time available, the person nominated does not have to be ready immediately to assume the Chairperson position. However, if someone who needs training is selected, the leadership team needs to make a concerted effort to provide that training during the year.

History of Officers by Appointment Category

While the Operating Policies do not provide any strict guidance about which type of appointment categories should be included for consideration as officers, over the last several years there has been an informal rotation between the categories. The policies do suggest that the Nominating Committee “consider including a direct consumer or family member in the slate of officers.”

Additionally, there has been some informal agreement about making sure that at least three different appointment categories are represented in the leadership positions: Chairperson, Chair-Elect, and Past-Chair.

I have provided the enclosure, “PC Officer Analysis”, to provide you with information for reviewing our previous chairpersons. Following the informal rotation, Professional/Provider is next in line.

Eligible Candidates

It is recommended that the nominee be a person who has served as a chair, vice-chair, or alternate chair of a committee or subcommittee due to the leadership skills and training that this experience provides.

Timeline

As mentioned above, the election will take place upon opening of the General Session of the January 2017 meeting. Thus, the Nominating Committee will need to complete the process and have its candidate recommendation prepared prior to the meeting. The first meeting will be scheduled in late November/early December for initial discussion of duties, of possible candidates, and designation of a chair for this committee. That would allow some time for the Nom Cmte Chair to contact the 1st choice (and 2nd or 3rd, if needed) before the January meeting.

E TAB SECTION

DATE OF MEETING 10/19/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 9/20/16

AGENDA ITEM:	Panel on Use of Psychotropic Medications for Foster Youth
ENCLOSURES:	Executive Summary State Auditor Report

The issue of the prescription of psychotropic medication to foster youth is of particular importance to California because we have the largest population of foster children in the country. The State Auditor's analysis of the available state data found that nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014-15, whereas studies suggest that only about 4 to 10 percent of nonfoster children are prescribed these medications.

To examine the oversight of psychotropic medications prescribed to foster children, the State Auditor reviewed case files for a total of 80 foster children in Los Angeles, Madera, Riverside, and Sonoma counties.

For more information regarding findings and recommendations, see the attached Summary of the report. Here is the link to the full report: <https://www.auditor.ca.gov/pdfs/reports/2015-131.pdf>

Here is a link to the full The Drug Docs report:
<http://www.dailydemocrat.com/article/NI/20160807/NEWS/160809922>

The Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) have convened a statewide quality improvement project to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care.

In order to meet the goals of the quality improvement project, three workgroups have been created. These include the Clinical Workgroup, the Data and Technology Workgroup, and the Youth, Family, and Education Workgroup. The progress of the project and the output of these three workgroups are reviewed by a panel of subject matter experts from around the State.

Lori Fuller, Chief of the Permanency Policy Branch at CDSS will present on the activity of the quality improvement project to address this issue.

A former Foster Youth, who was prescribed psychotropic medication, will present about their experience.



Report 2015-131 Summary - August 2016

California's Foster Care System:

The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care

HIGHLIGHTS

Our audit concerning the oversight of psychotropic medications prescribed to California's foster children revealed the following:

- Nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014-15.
- Some foster children were prescribed psychotropic medications in amounts and dosages that exceeded state guidelines, and counties did not follow up with prescribers to ensure the appropriateness of these prescriptions.
- Many foster children did not receive follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications.
- Counties did not always obtain required court or parental approval for psychotropic medications prescribed to foster children as required by law.
- The State's fragmented oversight structure of its child welfare system has contributed to weaknesses in the monitoring of foster children's psychotropic medications.
- The California Department of Social Services and the Department of Health Care Services data systems together cannot completely identify which foster children are prescribed psychotropic medications.
- Foster children's Health and Education Passports—documents summarizing critical health and education information—contained inaccurate and incomplete mental health data.

Results in Brief

Psychotropic medications such as antidepressants, mood stabilizers, and antipsychotics can provide significant benefits in the treatment of psychiatric illnesses, but they can also cause serious adverse side effects. Although the American Psychological Association has mentioned that studies since the 1970s have found that children in foster care (foster children) often have a greater need for mental health treatment, public and private entities have expressed concerns

about the higher prescription rates of psychotropic medication among foster children than among nonfoster children. This issue is of particular importance to California, which has the largest population of foster children in the country. In fact, our analysis of the available state data found that nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014-15, whereas studies suggest that only about 4 to 10 percent of nonfoster children are prescribed these medications.

To examine the oversight of psychotropic medications prescribed to foster children, we reviewed case files for a total of 80 foster children in Los Angeles, Madera, Riverside, and Sonoma counties and analyzed available statewide data. We found that many foster children had been authorized to receive psychotropic medications in amounts and dosages that exceeded the State's recommended guidelines (state guidelines), circumstances that should have prompted the counties responsible for their care to follow up with the children's prescribers. For example, 11 of the 80 children whose files we reviewed had been authorized to take multiple psychotropic medications within the same drug class. Further, 18 of the 80 children had been authorized to take psychotropic medications in dosages that exceeded the State's recommended maximum limits. Medications that exceed the State's recommended guidelines may be appropriate under some circumstances, and we are not questioning prescribers' medical expertise. However, in the instances above, the counties did not contact the prescribers to ensure the safety and necessity of the medications in question, as the state guidelines recommend.

Compounding these concerns is the fact that many of these children do not appear to have received follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications. The American Academy of Child and Adolescent Psychiatry recommends that children should receive follow-up visits with their health care providers ideally within two weeks, but at least within a month, after they start psychotropic medications. Nonetheless, one-third of the 67 foster children who started at least one psychotropic medication during our audit period did not receive follow-up appointments with their prescriber or other health care provider within 30 days after they began taking new psychotropic medications, thus increasing the risk that any harmful side effects would go unaddressed. In addition, our review of the 80 case files indicates that foster children did not always receive corresponding psychosocial services before or while they were taking psychotropic medications, even though such services are critical components of most comprehensive treatment plans.

In response to a recent state law, the Judicial Council of California adopted new and revised forms—which became effective in July 2016—to be used in the court authorization process for foster children's psychotropic medications. The proper completion of these newly revised forms should provide county staff with additional information necessary to identify instances when foster children are prescribed psychotropic medications in amounts or dosages that exceed the state guidelines. Among other things, these revised forms require prescribers to explain for each foster child why they prescribed more than one psychotropic medication in a class or dosages that are outside the state guidelines. If these forms are not properly completed, county staff will need to follow up with prescribers to obtain information necessary to ensure that the prescriptions beyond the state guidelines are appropriate.

We also found that, in violation of state law, counties did not always obtain required court or parental approval before foster children received prescriptions for psychotropic medications. Specifically, when we reviewed the case files for 67 foster children who should not have received psychotropic medications without authorization from a juvenile court, we found that 23 (34 percent) did not contain evidence of such authorization for at least one psychotropic medication. Similarly, when we reviewed the case files for 13 foster children who should not have received psychotropic medications without the consent of their parents, we found that five (38 percent) did not contain evidence of such consent for at least one psychotropic medication. In effect, these children were prescribed psychotropic medications without proper oversight from the counties responsible for their care.

Further, the fragmented structure of the State's child welfare system contributed both to the specific problems we identified in our review of the 80 case files and to larger oversight deficiencies that we noted statewide. Specifically, oversight of the administration of psychotropic medications to foster children is spread among different levels and branches of government, leaving us unable to identify a comprehensive plan that coordinates the various mechanisms currently in place to ensure that the foster children's health care providers prescribe these medications appropriately. Although the different public entities involved have made efforts to collaborate, the State's overall approach has exerted little system-level oversight to help ensure that these entities collective efforts actually work as intended and produce desirable results.

The State's fragmented oversight structure has also contributed to its failure to ensure it has the data necessary to monitor the prescription of psychotropic medications to foster children. The two state entities most directly involved in overseeing foster children's mental health care are the California Department of Social Services (Social Services) and the Department of Health Care Services (Health Care Services). Even when combined, results from data systems these two departments operate still contain inaccurate and incomplete data related to foster children who are prescribed psychotropic medications. Consequently, neither agency can completely identify which foster children statewide are prescribed psychotropic medications or which medications those children are prescribed.

Further, the inaccurate and incomplete information in Social Services data system is used to produce Health and Education Passports, which are critical documents that are meant to follow foster children should their placement change. We found that all 80 of the Health and Education Passports we reviewed contained instances of incorrect start dates for psychotropic medications. Moreover, 13 of these 80 Health and Education Passports did not identify all the psychotropic medications that the courts authorized, and all 80 were missing information about the corresponding psychosocial services the foster children should have received for at least one psychotropic medication. These errors and omissions appear to have been caused in large part by a lack of county staff to enter foster children's health information into Social Services data system and an unwillingness of some county departments to share foster children's information with each other. However, caretakers, health care providers, social workers, and others rely on the Health and Education Passports to make decisions about foster children's care; without accurate information, they may inadvertently make decisions that do not reflect the children's best interests.

Also, the State has missed opportunities to ensure that the counties have reasonable processes for overseeing the prescription of psychotropic medications to foster children. For example, Social Services California Child and Family Services Reviews of the counties only recently began examining in more depth psychotropic medications prescribed to foster children. Because Social Services and Health Care Services have not historically examined the prescription of psychotropic medications to foster children in their periodic reviews, they have missed opportunities for in-depth, county-by-county reviews of this issue. However, as of March 2016, both departments had begun collecting from the counties certain information about these medications.

Finally, rather than publishing this audit report in June 2016 as originally intended, we had to delay publication by two months to allow us time to obtain and analyze additional data from Health Care Services and to revise the report's text and graphics accordingly. In November 2015, our office began analyzing data originally provided by Health Care Services in response to our request for all Medi-Cal data related to the provision of psychotropic medications and related psychosocial services to foster children. These data provided the basis for the audit report we intended to publish in June 2016. However, about one week before we were to originally publish our audit report, Health Care Services confirmed that it had not provided all the medical services data that we originally requested. Although it had provided us data for medications, treatment authorizations, and services provided by specialty mental health plans, it had not given us services data for managed care plans or fee-for-service providers.¹ Our review showed that the additional June 22, 2016, data consisted of approximately 617 million medical service records. The related text and graphics in our audit report reflect a consolidation of the original more than 46 million medical service records provided by Health Care Services in November 2015 and the additional 617 million medical service records it subsequently provided on June 22, 2016, for a total of more than 663 million claims for medical services. Because the results from the consolidated data did not substantively affect the conclusions we reached originally or the recommendations we made, we did not ask the auditees to resubmit their written responses to our June 2016 draft report.

Recommendations

Legislature

The Legislature should require Social Services to collaborate with its county partners and other relevant stakeholders to develop and implement a reasonable oversight structure that addresses, at a minimum, the insufficiencies in oversight and monitoring of psychotropic medications prescribed to foster children highlighted in this report.

California Department of Social Services

To improve the oversight of psychotropic medications prescribed to foster children, Social Services should collaborate with counties and other relevant stakeholders to develop and implement a reasonable oversight structure that addresses, at a minimum, the monitoring and oversight weaknesses highlighted in this report and that ensures the accuracy and completeness of Social Services data system and the resulting Health and Education Passports.

Counties

To better ensure that foster children only receive psychotropic medications that are appropriate and medically necessary, counties should take the following actions:

- Implement procedures to more closely monitor requests for authorizations for psychotropic medications for foster children that exceed the state guidelines for multiple prescriptions or excessive dosages. When prescribers request authorizations for prescriptions that exceed the state guidelines, counties should ensure the new court authorization forms contain all required information and, when necessary, follow up with the prescribers about the medical necessity of the prescriptions. Counties should also document their follow-up in the foster children's case files. In instances in which counties do not believe that prescribers have adequate justification for exceeding the state guidelines, counties should relay their concerns and related recommendations to the courts or the children's parents.
- Ensure that all foster children are scheduled to receive a follow-up appointment within 30 days of starting a new psychotropic medication.
- Implement a process to ensure that foster children receive any needed mental health, psychosocial, behavioral health, or substance abuse services before and concurrently with receiving psychotropic medications.
- Implement a systemic process for ensuring that court authorizations or parental consents are obtained and documented before foster children receive psychotropic medications.

Agency Comments

The state entities and the counties agreed with our recommendations.

Further, Madera County told us that because it agreed with our report's recommendations, it did not intend to submit a written response. We look forward to assessing Madera County's implementation of our recommendations when it provides updates to us at 60 days, 6 months, and one year following the issuance of our report.

¹Please see Figure 2 in the Introduction for a depiction of the types of Medi Cal providers.

- **[View this entire report in Adobe Portable Document Format \(PDF\)](#)**
- Agencies/Departments Related to This Report:
 - **[Health Care Services, Department of](#)**
 - **[Legislature](#)**
 - **[Los Angeles County](#)**
 - **[Madera County](#)**
 - **[Medical Board of California](#)**
 - **[Riverside, County of](#)**
 - **[Social Services, Department of](#)**
 - **[Sonoma County](#)**

Exploring a New Landscape: Use of Psychotropic Medication in Foster Care

Lori Fuller, Bureau Chief, CFSD

Exploring a New Landscape

The California Department of Social Services (CDSS) has helped shape policy and implement laws relating to psychotropic medications for youth in foster care.

- ▶ In 2015, Senate Bills (SB) 484, 238, and 319 were signed by the governor to provide clearer guidelines and oversight of the usage of psychotropic medications by youth in foster care.
- ▶ Changes to policy began with the Quality Improvement Project: Improving Psychotropic Medication Use Among Children And Youth In Foster Care (QIP).

Quality Improvement Project: Improving Psychotropic Medication Use Among Children And Youth In Foster Care (QIP).

Lori Fuller

QIP History

- ▶ QIP addressed oversight and monitoring through a sequence of workgroups targeting issues such as:
- ▶ Engaging foster youth in their care and treatment.
- ▶ Increasing the monitoring of medications and dosages.
- ▶ Reducing inappropriate concurrent use of multiple psychotropic medications.
- ▶ Using data to analyze and oversee improvement in the safe use of psychotropic medication.
- ▶ Creating educational materials for use by prescribing physicians, providers, social workers, probation officers, caregivers, youth and families.

QIP Workgroups

▶ Clinical Workgroup

- Developed and distributed "Guidelines for Use of Psychotropic Medication with Children and Youth in Foster Care" (<http://www.dhcs.ca.gov/services/Pages/qip.aspx>)
- Submitted recommendations to the Judicial Council for improvements to the JV220 process

▶ Youth, Family, and Education Workgroup

- Youth Bill of Rights in a youth-friendly brochure
- Questions to Ask about Medications document in a youth-friendly brochure
- Wellness Workbook

QIP Workgroups Continued

- ▶ Data and Technology Workgroup
 - Distributed case-level JV220 reconciliation reports to counties
 - Publically posted two measures: Use of Psychotropic and Antipsychotic Medications
 - Developed seven child welfare measures
- ▶ Medication Protocol Development Workgroup
RESOURCE GUIDE – Medications in Group Homes

QIP Workgroups Continued

- Psychotropic Medication Legislation Implementation Workgroup
 - Identify Core Training Elements for the Development of New Psychotropic Medication Training Materials
 - Provide Information to Facilitate Regulation Development
 - Develop Form for Sharing of Data and Information With the Court, Child's Attorney, and Court Appointed Special Advocates
- ▶ **ACIN I-69-13 – “Improving Psychotropic Medication Use Among children In Foster Care: The Quality Improvement Project”**

Quality Improvement Project – Resources & Information

- ▶ Website <http://www.dhcs.ca.gov/services/Pages/qip.aspx>
All QIP work products are posted on the DHCS website.
- ▶ [California](#) Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care
- ▶ [Questions to Ask about Medications](#)
- ▶ [Foster Youth Mental Health Bill of Rights](#)
- ▶ QIP mailbox: qipfostercare@cdss.ca.gov– If you have questions or wish to join a workgroup e-mail this mailbox

SB 238 Implementation: Legislation

- ▶ Outlines criteria for the use of psychotropic medication for children and youth in foster care, and requires data sharing agreements between DHCS, CDSS and county placing agencies.
- ▶ Requires CDSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report with specified information regarding foster youth taking psychotropic medications.
- ▶ Requires county placing agencies to use a form to share information with designated parties.

SB 238 Implementation: Legislation

- ▶ Requires CDSS in consultation with stakeholders to develop training for social workers, probation officers, court staff, children's attorneys, children's caregivers, CASAs.
- ▶ Training will address authorization, uses, risks, benefits, assistance with self-administration, oversight, and monitoring of psychotropic medications, trauma and substance use disorder treatments, and how to access those treatments.

SB 238 Implementation: Legislation

- ▶ Requires CDSS to provide data reports to counties who have signed onto the Global Data Sharing Agreement with CDSS and DHCS.
- ▶ Reports would at a minimum include authorized psychotropic medications with medication name, quantity and dosage prescribed and available data regarding psychosocial interventions and incidents of polypharmacy.
- ▶ Requires CDSS, in consultation with DHCS and stakeholders to develop a form to be utilized in sharing information from data reports to court, child's attorney, Behavioral Health, and CASAs.

Global Interagency Data Sharing Information

- ▶ Three–Way Agreement
 - California Department of Social Services
 - California Department of Health Care Services
 - County Government (potentially 58 counties)
- ▶ Authorizes data sharing for the care of children with an open child welfare case
- ▶ Provides process to identify data to exchange and document data sharing activities

New Child Welfare Data Measures

- ▶ Use of Psychotropic Medications
- ▶ Use of Antipsychotic Medications
- ▶ Use of Multiple Concurrent Medications for Youth in Foster Care
- ▶ Ongoing Metabolic Monitoring for Youth in Foster Care on Antipsychotic Medication
- ▶ Use of First-Line Psychosocial Care for Youth in Foster Care on Psychotropic Medication
- ▶ Follow-Up Visit for Youth in Foster Care on Psychotropic Medication
- ▶ Metabolic Screening for Youth in Foster Care Newly on Antipsychotic Medication

Application Regarding Psychotropic Medication expanded

- ▶ The Judicial Council, in consultation with other stakeholders, developed new Rules of Court and forms to implement the additional components of the court authorization process added by SB 238.
- ▶ For “Rules of Court”, visit : [Title Five Rules](#)
- ▶ JV-217 through JV-224 are available online at www.courts.ca.gov. Read JV-217 INFO for information about the required forms.

SB 238 Implementation: Training

What is the goal of the training?

- ▶ To inform relevant staff who work with children under the jurisdiction of the juvenile court that address the authorization, uses, risks, benefits, assistance with self-administration, oversight, and monitoring of psychotropic medications, trauma, and substance use disorder and mental health treatments, including how to access those treatments

Who will the training be available to?

- ▶ **Via eLearning:**
- ▶ Judges
- ▶ Children's attorneys
- ▶ Children's caregivers
- ▶ Court-appointed special advocates
- ▶ Any other relevant staff that work with children under the jurisdiction of the juvenile court
- ▶ **Via classroom setting:**
- ▶ Social Workers, Probation officers, and Public Health Nurses
- ▶ **Via vendors and community colleges:**
- ▶ Existing Administrator and Foster Parent training curriculums will be adapted to comply with SB 238 requirements

Topics to include in training curriculum

- ▶ Authorization process for the use of psychotropic medication
- ▶ Psychosocial and psychotropic medication treatment plan
- ▶ Trauma – PTSD, trauma–informed crisis management planning
- ▶ Substance use disorder
- ▶ Mental health treatments

- ▶ For more information go to: [ACL 16–37](#)

How SB 484 is changing the way we monitor youth in out of home care

- ▶ Adds additional record keeping/document requirements related to psychotropic medications for group home facilities to maintain in the child's file.
- ▶ Requires CDSS to compile specified information regarding the administration of psychotropic medications to children in foster care in group homes based on data from DHCS and at least annually post on its website.

How SB 484 is changing the way we monitor youth in out of home care

- ▶ Requires CDSS, in consultation with the DHCS and stakeholders, to establish a methodology to identify those group homes that have levels of psychotropic drug utilization warranting additional review, and to inspect identified facilities at least once a year.
- ▶ Share relevant information from inspections with county placing agencies, social workers, probation officers, court, minor's attorneys, or medical board if applicable and/or with facilities and develop appropriate plans of action.

Facility Inspections

- ▶ Methodology adopted:
 - Using matched DHCS and CDSS data, the top 25% of group home facilities with highest psychotropic medication utilization rates relative to their RCL will be inspected.
 - These inspections will be conducted by Community Care Licensing and will include:
 - Case File Reviews
 - Youth Interviews
 - Group Home Staff Interviews

Facility Inspections continued...

- ▶ Following an inspection by CCLD, and as appropriate, CCLD may share relevant information and observations with the respective group home facility to address any identified risks related to psychotropic medication.
- ▶ CDSS may require the facility to submit a plan to address the identified risks related to psychotropic medication.
- ▶ Every three years, CDSS will be required to consult with DHCS and stakeholders to revise the methodology, if necessary. Methodology will be revised to incorporate changes to congregate care facilities resulting from statewide implementation of CCR in 2017.

For more information:

- ▶ Implementation Plans are available at:
<http://cclid.ca.gov/res/pdf/16APX-04.pdf>
- ▶ New [Resource Guide for Medications in Group Homes](#) is also now available!
- ▶ View [ACIN I-25-16](#)

Legislation

SB 319

- ▶ Amends WIC section 16501.3(c)(3) to add “monitoring and oversight of psychotropic medications” to the list of activities included in the planning and coordination of health care that may be performed by the foster care public health nurse.
- ▶ Adds foster care public health nurses to the list of allowable parties with whom health care providers can disclose medical information to for the purposes of coordinating healthcare services and medical treatment.

Legislation SB 319

- ▶ Additionally, WIC section 16501 (c) (5) also includes that at the request of and under the direction of a non-minor dependent, the public health nurse shall assist non-minor dependents in making informed decisions about their health care by at a minimum, providing educational resources and materials.
- ▶ For more information go to: [ACL 16-48](#)

Conclusion

- ▶ This workshop is intended to give you a deeper perspective on a topic that is currently receiving significant attention from media, advocates, and the legislature. We hope that you feel more informed about the issues and we appreciate your participation!

Thank you!

Q&A

G TAB SECTION

DATE OF MEETING 10/19/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 9/19/16

AGENDA ITEM:	Panel of Counties re: Implementation of Continuum of Care Reform (CCR)
ENCLOSURES:	Various Fact Sheets re: Implementation of CCR

On January 1, 2017, every county in California will be expected to implement their plan for the Continuum of Care Reform (CCR). CCR is a collaborative process between departments of social services (child welfare services) and behavioral health, both at the state and county levels, to improve outcomes for children involved in the Child Welfare System.

This panel of county Behavioral Health and Child Welfare Services representatives has been created to provide Council members with information about how various counties in California are actively developing their implementation plans. The various fact sheets attached are provided for an overview of the state/county policies and timelines for the implementation. From the panel members, we will hear what it looks like on the ground.

More information and fact sheets on CCR can be found on the CSS website at <http://www.cdss.ca.gov/ccr>

Panelists include:

El Dorado County- Patricia Charles-Heathers, Director and Alexis Zoss, Chief Assistant Director

San Joaquin County- Jacqueline Coulter, Deputy Director of Children and Youth Services and Mikey Habbestad, Deputy Director of Child Welfare (invited)

Trinity County- Noel O'Neill, Director

Yolo County- Kathleen Barrett, Clinical Supervisor-Quality Management, Adult & Aging Branch and Alexandria Nelson, Social Worker Supervisor II, Child Welfare Services



CONTINUUM OF CARE REFORM

CCR builds on California's current reform efforts

Approved Relative Caregivers Program (ARC)

Participating counties support relative caregivers with a payment equal to the basic foster care rate.

Resource Family Approval (RFA) Program

A pilot program which provides upfront training and assessment of families seeking to parent children in foster care will expand statewide.

Quality Parenting Initiative

Will create new strategies and practices within child welfare for the recruitment and retention of quality caregivers, and support biological parents with reunification efforts.

Child and Family Teaming

The newly developed child welfare "Core Practice Model" recognizes that a team approach to case planning and care delivery is critical to effectively care for all children and youth in foster care.

Pathways to Mental Health

Originating from the Katie A. lawsuit settlement, Pathway's aims for children in foster care to receive medically necessary mental health services they are entitled to under Medi-Cal and that those services are available in a family setting.

WHAT IS THE CONTINUUM OF CARE REFORM?

The Continuum of Care Reform (CCR) draws together a series of existing and new reforms to our child welfare services program. CCR is designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed nurturing family homes. Continuum of Care Reform, also known as AB 403, provides the statutory and policy framework to ensure services and supports provided to the child or youth and his or her family are tailored toward the ultimate goal of maintaining a stable permanent family. Reliance on congregate care should be limited to short-term, therapeutic interventions, which is just one part of a continuum of care available for children, youth and young adults.

THE FUNDAMENTAL PRINCIPLES OF CCR ARE:

- All children deserve to live with a committed, nurturing, and permanent family that prepares youth for a successful transition into adulthood.
- The child, youth and family's experience, along with, voice is important in assessment, placement, and service planning. A process known as a "child and family team," which includes the child, youth and family, and their formal and informal support network will be the foundation for ensuring these perspectives are incorporated throughout the duration of the case.
- Children should not have to change placements to get the services and supports they need. Research shows that being placed in foster care is a traumatic experience and in order for home-based placements to be successful, services including behavioral and mental health should be available in a home setting.
- Agencies serving children and youth including child welfare, probation, mental health, education, and other community service providers need to collaborate effectively to surround the child and family with needed services, resources, and supports rather than requiring a child, youth, and caregivers to navigate multiple service providers.
- The goal for all children in foster care is normalcy in development while establishing permanent life-long family relationships. Therefore, children should not remain in a group living environment for long periods of time.



Statutory Timelines

The current licensure and rate structures for group homes and Foster Family Agencies (FFAs) will sunset January 1, 2017.

CDSS will establish new licensure and rate systems for STRTCs and FFAs beginning January 1, 2017.

For the next two years, group homes at a county placing agency request can receive an extension to operate for an additional two years. This provides for further annual extensions at the request of county probation agencies.

The accreditation of STRTCs and FFAs will start in 2016 and is expected to take 2-3 years.

Children are expected to start stepping down from group homes 1-2 years into family-based care.

IMPLEMENTATION EFFORTS FOR CCR WILL OCCUR IN STAGES BETWEEN NOW AND 2021 IN CHILD WELFARE SERVICES, AND IN SUCCEEDING YEARS IN PROBATION FOSTER CARE.

- Group care will be primarily utilized only for Short-Term Residential Therapeutic Centers (STRTCs) that provide intensive treatment interventions. When needed, the STRTC placement option will be available to children and youth requiring highly intensive 24-hour supervision and treatment, designed to quickly transition children back to their own or another permanent family.
- Facilities seeking licensure as a STRTC will need to meet higher standards of care, be accredited, and be able to deliver or arrange for a set of core services including the mental health services that children need. A new rate structure is being developed for these programs.
- Foster Family Agencies (FFAs) are re-envisioned to provide various levels of care to meet a broader range of individual child needs. Like STRTCs, FFAs will make available a core set of services that are trauma-informed and culturally relevant, including specialty mental health services. The FFAs, at the request of a county, may provide supports and services to county-approved families, including relatives. A new rate structure is being developed to support this change.
- Statewide implementation of the Resource Family Approval (RFA) process will improve selection, training, and support of families under a streamlined, family friendly process for approving families (including relatives) seeking to care for a child in foster care, whether on an emergency, temporary, or permanent basis. All families will receive training.
- Resources are being provided to counties to support the development and implementation of creative strategies for supporting, retaining, and recruiting quality relative and non-relative resource families.
- Services and supports will be tailored to the strengths and needs of a child and delivered to the child/youth in a family-based environment. These services and supports will be informed by an assessment and developed through a child and family team process.
- Increases accountability and transparency of FFAs and STRTCs. This approach includes:
 - Accreditation by a national accrediting body
 - Publicly available provider performance measures
 - Consumer satisfaction surveys
 - Interdepartmental oversight framework

MORE INFORMATION AND QUESTIONS

- [CCR: A Report to the Legislature](#)
 - [Assembly Bill 403 \(Chapter 773, Statutes of 2015\)](#)
- For additional information or questions, please contact: CCR@dss.ca.gov.



CONTINUUM OF CARE REFORM

CCR builds on California's current reforms

Approved Relative Caregivers Program (ARC)

Currently 45 participating counties support relative caregivers with a payment equal to the basic foster care rate.

Child and Family Teaming

An effective approach to coordinated care and case planning for all children and youth in the child welfare system.

Pathways to Mental Health

Originating from the Katie A. lawsuit settlement, Pathways is intended to improve the coordination between child welfare and mental health systems so that children in foster care receive timely, and effective individualized mental health services.

Quality Parenting Initiative

Will create new strategies and practices within child welfare for the recruitment and retention of quality caregivers, and support biological parents with reunification efforts.

Residentially-Based Services Reform (RBS)

Currently, a four county demonstration project begun in 2008 that tested a short-term residential program model with ongoing community-based services and support, and which serves as the foundation for STRTC.

Resource Family Approval (RFA) Program

In 2017, a five-county pilot that provides upfront training and assessment of families seeking to parent children in foster care will expand statewide.

SHORT-TERM RESIDENTIAL THERAPEUTIC CENTERS

The Continuum of Care Reform seeks to realize California's longstanding goal of ensuring that all children live as members of committed, nurturing, and permanent families. Research indicates that children remaining in group care for long periods of time have poorer outcomes than those living in a family setting, including a higher likelihood of arrest, homelessness, and reentry to foster care. The current policy framework for group care has not kept pace with child welfare and mental health practice and desired outcomes. However, this type of care – often group homes characterized by large campus facilities and staff who care for children in shifts – remains a high cost placement option for children in foster care.

Based on broad stakeholder input, the Continuum of Care Reform effort will phase out traditional group homes as a foster care placement and target the use of group care to Short-term Residential Therapeutic Centers (STRTCs) intended to provide short-term, high quality, intensive interventions that are just one part of a continuum of care available for children in foster care. Services will be designed to transition them back home or to another permanent family as soon as possible.

Assembly Bill 403, the legislation implementing the Continuum of Care Reform, recognizes that achieving this goal requires significant changes to the way that group care is paid for and performance and outcomes monitored. Some key efforts are:

- Facilities seeking licensure as a STRTC must demonstrate the capacity to meet the treatment level needs of children and make available an array of "core services" including mental health services, in order to transition quickly back to a home based family placement.
- Requires STRTCs to directly, or through organizational relationships, approve resource families in order to ensure that all children residing in the facility have a plan in place for their return to a home based family setting.
- The STRTC will be required to develop new plans of operation, training plans, and program statements that reflect the changed practices and services to be provided allowing for improved transparency and accountability.
- The STRTC must be certified by the county mental health plan or have a relationship with a certified provider and directly deliver or arrange for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) specialty mental health services that children and youth in their care need.
- A new rate structure is being developed for STRTC programs to reflect these changes.
- Development of a standardized assessment process to promote better coordination of services and to ensure that the individual needs of each child are considered and met.



- The STRTC will be required to obtain and maintain national accreditation from approved accrediting bodies as a condition of licensure.
- Requires the development of a coordinated monitoring and oversight system between the California Department of Social Services and the Department of Health Care Services

STATUTORY TIMELINES

- The current licensure and rate structures for group homes and foster family agencies will sunset January 1, 2017, unless an extension is granted permitting a facility to continue operation as a group home or Foster Family Agency (FFA) under the existing rate structure.
- The California Department of Social Services will establish new licensure and rate systems for STRTCs and FFAs beginning January 1, 2017.
- For the next two years, group homes at a county placing agency request can receive an extension to operate for an additional two years. Statute provides for extensions beyond two years at the request of providers with supporting documentation from county probation agencies.
- The accreditation of STRTCs and FFAs will start in 2016 and is expected to take two to three years.
- Provision licensure as a STRTC or FFA is permitted for up to two years in order to secure accreditation.

MORE INFORMATION AND QUESTIONS

- [CCR: A Report to the Legislature](#)
- [Assembly Bill 403 \(Chapter 773, Statutes of 2015\)](#)
- For additional information or questions, please contact: CCR@dss.ca.gov.



CONTINUUM OF CARE REFORM

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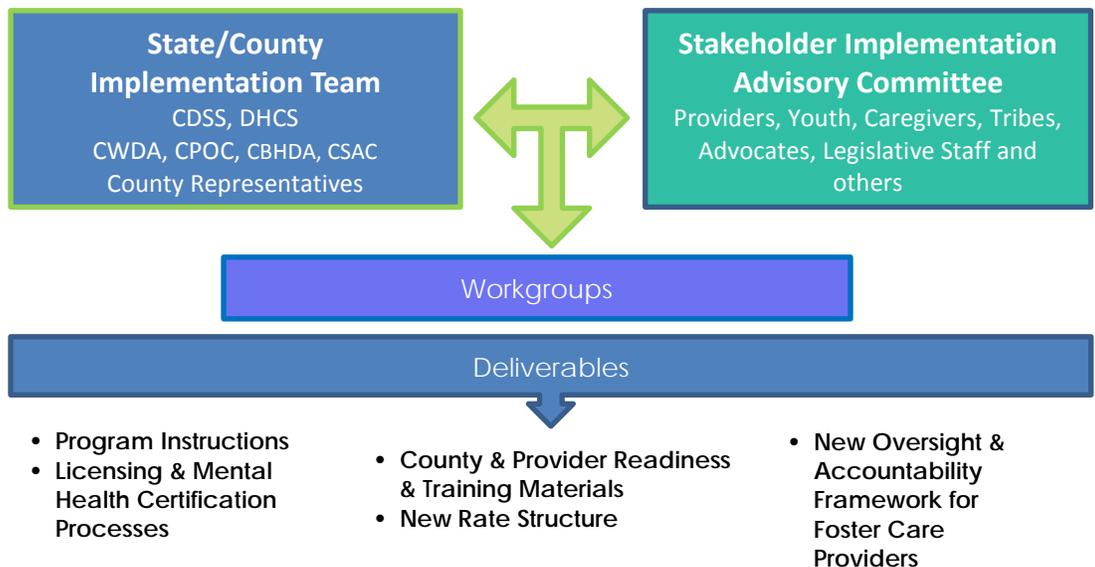
In 2017, a five-county pilot that provides upfront training and assessment of families seeking to parent children in foster care will expand statewide.

IMPLEMENTING THE CONTINUUM OF CARE REFORM

[Continuum of Care Reform](#) (CCR) including the public policy changes brought about by Assembly Bill 403 (Stone, Chapter 773, Statutes of 2015), brings together new and existing reforms to our child welfare services program designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed, nurturing family homes. Implementation of these reforms will be a multiyear effort that cuts across various levels and branches of government, the public and private human services delivery sector and a wide array of stakeholders with diverse interests.

The California Department of Social Services, in collaboration with the Department of Health Care Services, is the lead state agency for implementation. Because of the complex nature of the reform, development of an implementation stakeholder advisory framework is underway:

Proposed CCR Implementation Advisory Framework:



IMPLEMENTATION TIMELINES

- The [accreditation](#) of [Short-term Residential Therapeutic Centers \(STRTCs\)](#) and Foster Family Agencies (FFAs) will start in 2016 and is expected to take two to three years. Provisional licensure as a STRTC or FFA is permitted for up to two years or until December 31, 2018 in order to secure accreditation.
- In June 2016, policy instructions for the new licensing requirements and rates will be available for STRTCs and FFAs.
- Beginning January 1, 2017:
 - New licensure and rate systems for STRTCs and FFAs take effect.
 - Mental health certification requirements for STRTCs and FFAs take effect.
 - The current licensure and rate structures for group homes and foster family agencies sunset unless an extension is granted permitting a facility to continue operation as a group home under the existing rate structure.



- The new [Resource Family Approval](#) process goes statewide.
- Additional county review of children placed in STRTCs for more than six months.
- New and updated training requirements for resource families and foster care providers take effect.

MORE INFORMATION AND QUESTIONS

- [CCR: A Report to the Legislature](#)
- [Assembly Bill 403 \(Chapter 773, Statutes of 2015\)](#)
- For additional information or questions, please contact: CCR@dss.ca.gov.



CONTINUUM OF CARE REFORM

CCR builds on California's other efforts

Approved Relative Caregivers Program (ARC)

Currently 45 participating counties support relative caregivers with a payment equal to the basic foster care rate.

Child and Family Teaming

An effective approach to coordinated care and case planning for all children and youth in the child welfare system.

Pathways to Mental Health

Originating from the Katie A. lawsuit settlement, Pathways is intended to improve the coordination between child welfare and mental health systems so that children in foster care receive timely, and effective individualized mental health services.

Quality Parenting Initiative

Will create new strategies and practices within child welfare for the recruitment and retention of quality caregivers, and support biological parents with reunification efforts.

Residentially-Based Services Reform (RBS)

Currently, a four county demonstration project begun in 2008 that tested a short-term residential program model with ongoing community-based services and support, and which serves as the foundation for STRTC.

Resource Family Approval (RFA) Program

In 2017, a five-county pilot that provides upfront training and assessment of families seeking to parent children in foster care will expand statewide.

INTEGRATING MENTAL HEALTH SERVICES

The availability of a broad array of mental health services is essential to the proper support of children and youth placed in foster care as a result of abuse or neglect. The trauma experienced by these children can have long-term negative impacts to a child's developmental, social, emotional, and physical health. Services critical to managing the impacts of trauma include a continuum of mental health services. In California, "non-specialty" mental health services may be provided by a county's Managed Care Plan and "specialty" mental health services mandated under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program are provided, or arranged to be provided, through the county Mental Health Plan

The EPSDT Program is a comprehensive benefit package within Medicaid specifically for children up to age 21, and includes medical, dental, and mental health care services. All children involved with the foster care system are eligible for federal Medicaid benefits, called Medi-Cal in California. The EPSDT Program emphasizes prevention and early intervention, and requires that children receive comprehensive examinations to identify and address treatment needs.

California's Settlement Agreement in the *Katie A. v Bonta* lawsuit has led the state to take a series of actions intended to transform the way child welfare and mental health agencies provide entitlement specialty mental health services to children, youth, and families in the child welfare system. The Pathways to Mental Health Services is a result of the Katie A. Settlement Agreement and calls for the provision of a comprehensive array of services that are delivered in a coordinated manner, based in home or community settings, and tailored to meet the needs of individual children and families.

The Continuum of Care Reform (CCR) builds on these efforts and further ensures that children and youth in foster care receive services that meet their mental health needs regardless of the placement setting. Assembly Bill 403 (Stone; statutes of 2016), the legislation implementing CCR, recognizes that achieving this goal requires a high degree of collaboration and coordination between child welfare agencies and county mental health plans. Success also requires expanded availability of mental health services delivered in home and community-based settings. Some key efforts are:

- A universal assessment process will identify the needed service and supports, and facilitate the development of plans to meet the needs of the child, youth and families, including needs for mental health services.
- A Child and Family Team will be convened by child welfare and probation agencies for all children and youth in foster care to



develop needs and service plans, with participation from children, youth, families, caregivers, and professionals, including county mental health partners and clinicians.

- Facilities seeking licensure as a Short-term Residential Therapeutic Centers (STRTCs) must demonstrate the capacity to meet the treatment needs of children in order to transition them quickly to a home based family placement.
- Foster Family Agencies (FFAs) and STRTCs must have the capacity to deliver an array of “core services,” including in-home mental health services for family care placements to ensure children receive services they need regardless of their placement setting.
- STRTCs and FFA must be certified by the county mental health plan or have a relationship with a certified provider to directly deliver or arrange for the EPSDT specialty mental health services that children and youth need, as authorized by the county Mental Health Plan.
- A new rate structure is being developed for STRTC and FFA programs to reflect these changes.
 - Development of a standardized assessment process to promote better coordination of child welfare and mental health services
 - Requirement for STRTCs and FFAs to obtain and maintain formal accreditation from approved national accrediting bodies as a condition of licensure
 - Development of a coordinated monitoring and oversight system between the California Department of Social Services and the Department of Health Care Services in coordination with interested stakeholders such as youth, families, providers, and other advocates.

STATUTORY TIMELINES

- The current licensure and rate structures for group homes and FFAs will sunset January 1, 2017, unless an extension is granted.
- The California Department of Social Services will establish new licensure and rate systems for STRTCs and FFAs beginning on January 1, 2017.
- For the next two years, group homes at a county placing agency’s request can receive an extension to operate for an additional two years. Statute provides for extensions at the request of county probation agencies.
- The accreditation of STRTCs and FFAs begins in 2016, and is expected to take two to three years.

FOR MORE INFORMATION OR QUESTIONS

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ASSESSMENT

In child welfare and juvenile probation services an assessment process is used to gather information about the child's and family's strengths and needs, resiliency, current safety and risk for future abuse or neglect, mental health concerns, substance use, housing needs, employment, educational needs, access to and involvement with other community services providers, and exposure to trauma. This assessment provides the basis for the services and supports identified in the case plan that are to be provided to children and families. For instance, if the assessment indicates the child has developmental needs or mental health needs, referrals are made to the appropriate regional center or mental health provider for further assessment. The assessment also informs the placement needs of the child. Assessments are not a one-time event, but rather an ongoing process throughout the life of a case which inform updates to the case plan.

WHAT'S NEW?

Several years ago, state law increased the timeframe to develop the case from 30 to 60 days in order to allow more time to engage families and solicit their input into the case plan. Assembly Bill 403 reaffirms the expectation that the agency collaborate with the child, youth and family in the assessment and case planning process by defining the role of a [Child and Family Team](#). This practice is consistent with the [California Child Welfare Core Practice Model](#) under development by California county child welfare agencies.

Using mental health as an example, if the information gathered in the child and family assessment process identifies that a child or youth has mental health needs the child or youth is then referred to an appropriate provider. This process is known as a mental health screening and is conducted upon initial entry into the foster care system and then generally annually thereafter.

In mental health settings, assessments are a formal practice which is more narrowly focused on an individual child and provides an in-depth evaluation of underlying needs and mental health concerns, including an assessment of psychosocial risk factors related to a child's environment including a trauma assessment component, as well as a clinical assessment of current functioning.

While child welfare and mental health assessment are different, they do overlap. The graphic below illustrates the interconnections between the two processes.



MORE INFORMATION AND QUESTIONS

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CONTINUUM OF CARE REFORM

ACCOUNTABILITY & OVERSIGHT

CCR builds on California's current reform efforts

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The Continuum of Care Reform (CCR) seeks to improve outcomes for children in foster care by strengthening the state's oversight framework of foster care providers, namely Foster Family Agencies and the new category, Short-Term Residential Therapeutic Centers. This framework will include three key strategies: national accreditation, cross-departmental state oversight and publicly available provider performance data.

BACKGROUND

Currently, state oversight of foster care providers is compartmentalized and relatively narrow in focus. Additionally, little data or information is available to the public or to county placing agencies regarding foster care providers.

WHAT WILL CHANGE?

- All providers will be accredited through a national accrediting organization.
- The CCR seeks to develop an oversight framework that integrates existing accountability and oversight processes (licensing, fiscal audits, mental health accountability) and new data measures into a more holistic approach to provider accountability.
- A core CCR principle assumes that information about provider performance is important to counties in making placement decisions and to providers to continuously improve the quality of their services by using data to manage performance. Provider performance measurements will be developed initially from existing administrative data sources: e.g., statewide child welfare data, qualitative case reviews, audits, licensing actions and data from other state agencies. Client satisfaction surveys will be used to capture the perception of children and their families regarding services they have received.

PROVIDER PERFORMANCE MEASURES

- The performance and measurement system will build from a number of existing and developing activities at the state and local levels.
- From these efforts, and in consultation with national experts, the Department will establish baselines of performance for providers so that improvement over time can be measured.
- Measures specific to probation youth outcome will also to be developed.

PUBLIC TRANSPARENCY

- Beginning 2017, the Department of Social Services will publish foster care provider performance indicators onto a publically available website and will update that information at least twice a year.

MORE INFORMATION AND QUESTIONS

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H TAB SECTION

DATE OF MEETING 10/19/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 9/20/16

AGENDA ITEM:	Council Discussion of Little Hoover Report on MHSA
ENCLOSURES:	“Promises Still to Keep, A Second Look at the Mental Health Services Act”

In January 2015, the Little Hoover Commission issued its initial report on the Mental Health Services Act. In that report, a number of recommendations were made to the Department of Health Care Services and Mental Health Services Oversight and Accountability Commission.

On May 26, 2016, the Commission held a follow-up hearing to determine what changes or progress had been made in addressing the findings and recommendations in their 2015 report. Council Member Daphne Shaw and Executive Officer Jane Adcock were invited to address the Commission during the hearing.

In September 2016, the Commission issued its second report on the Mental Health Services Act. This report again makes several findings and recommendations. In this report, the Mental Health Planning Council is mentioned and our role in oversight is discussed.

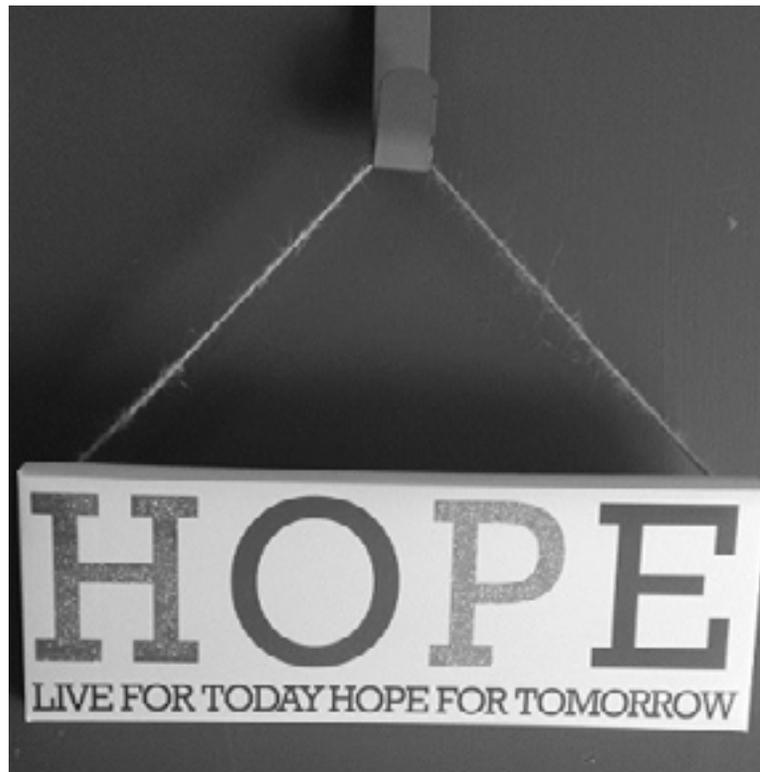
Below is the link to the Little Hoover Commission website regarding the press releases, hearing testimony and both the initial and most recent report “Promises Still to Keep, a Second Look at the Mental Health Services Act”

<http://www.lhc.ca.gov/studies/233/report233.html>

The Council members will have an opportunity to discuss and ask questions during this time on the agenda for this item. Additionally, it is anticipated that during his agenda time, Executive Director Toby Ewing of the Mental Health Services Oversight and Accountability Commission will discuss the findings and recommendations related to his organization and any activities they have planned to address them.

***PROMISES STILL TO KEEP: A SECOND LOOK
AT THE MENTAL HEALTH SERVICES ACT***

REPORT #233, SEPTEMBER 2016



A LITTLE HOOVER COMMISSION LETTER REPORT TO
THE GOVERNOR AND LEGISLATURE OF CALIFORNIA

To Promote Economy and Efficiency

Little Hoover Commission

Pedro Nava
Chairman

Jack Flanigan
Vice Chairman

Scott Barnett

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Anthony Cannella
Senator

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The Little Hoover Commission, formally known as the Milton Marks “Little Hoover” Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

Cover photo by Little Hoover Commission staff at Hacienda of Hope – Project Return Peer Support Network, Long Beach, California.

Contacting the Commission

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This report is available from the Commission's website at www.lhc.ca.gov.

LETTER FROM THE CHAIR

September 8, 2016

The Honorable Edmund G. Brown, Jr.
Governor of California



The Honorable Kevin de León
President pro Tempore of the Senate
and members of the Senate

The Honorable Jean Fuller
Senate Minority Leader

The Honorable Anthony Rendon
Speaker of the Assembly
and members of the Assembly

The Honorable Chad Mayes
Assembly Minority Leader

Dear Governor and Members of the Legislature:

More than a decade ago, California voters passed a landmark tax initiative that promised to expand access to mental health services and transform how people get help by providing services, when and where needed, at any stage of an illness.

For some Californians, the Mental Health Services Act (MHSA) has fulfilled this promise. Proposition 63-funded programs have helped individuals with mental illness recover and thrive. For some, the funding created programs that offer housing, healthcare, medication and help to become self-sufficient. For others at risk of developing mental illness, the funding provides safe, supportive local centers to stay and work through episodes of crisis. These are but two examples of the types of programs in which counties invest money from the Act. Throughout this report we offer a glimpse into nine programs the Commission visited this year and give voice to some who have benefited from these programs.

But these inspiring stories of success are shadowed by a continuing failure of the state to demonstrate what is collectively being accomplished. The state still can't provide conclusive data to show how it is keeping promises made to voters in 2004, or to wealthy taxpayers who fund Proposition 63 programs with a 1 percent surtax, and most importantly, to the individual Californians and their families who rely on these services for much-needed help. Others have shown this can be done. The County Behavioral Health Directors Association partnered with a non-profit public policy institute to release two reports showing successful outcome measures for county full-service partnership program participants.

In its January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*, the Commission called on the state to better validate how money generated by the Act is used. The report cited a dispersed governance system with no definitive center of leadership. It also found a lack of meaningful data to account for expenditures or demonstrate outcomes to paint a picture of who is being served. In May 2016, the Commission revisited the topic, inviting relevant agencies, as well as stakeholders, to discuss progress in addressing shortcomings raised in the Commission's 2015 review.

Despite some encouraging developments, many of the same concerns remain. The Commission heard repeatedly from stakeholders desperate for more oversight of the Act and concerned about the lack of

consequences for bad behavior. Many said the processes to oversee the distribution and use of MHSA funds at the local and state levels are still woefully inadequate and leave those with questions or concerns confused about where to get answers. Others said that without more detailed demographic data, policymakers won't know whether more can or should be done to reach underserved communities.

The Commission admits to remaining somewhat baffled by the extreme complexity of interlaced agencies and data reporting systems that collectively still can't handily tell taxpayers how their money is being spent, who is being helped and what impact it is making. Though Proposition 63 created a new entity to oversee programs funded by the Act, the Little Hoover Commission has questioned why an oversight commission exists if it cannot deliver meaningful oversight. Additionally, though the Department of Health Care Services is empowered and funded to enforce the Act, this responsibility appears to be lost among others. Without strong leadership at the top, it is uncertain who is responsible to look out across the system to see what is working and make sure those lessons are being shared statewide. The state itself spends more than \$100 million from the MHSA and there is little oversight of that spending, beyond the regular budget process.

It is clearer than ever in the wake of the Commission's second review that the state must identify a well-defined leader to administer, oversee and enforce the MHSA or it will remain difficult to articulate a cohesive vision for the Act and ensure accountability to alleviate many of the visible statewide impacts of mental illness. This leader also should take charge to ensure counties are appropriately engaging stakeholders and that success stories are shared statewide.

Consequences of a long-standing inability to demonstrate the value of statewide Proposition 63-funded programs are already apparent. Lawmakers have begun chipping away at this lucrative funding source. Recently enacted legislation championed by the Steinberg Institute steers \$130 million in annual proceeds to finance a \$2 billion bond for supportive housing for homeless individuals with mental illness. This is one way to inject state priorities and accountability into how MHSA funds are used. Some, however, expressed concerns to the Commission that this may open a floodgate for setting additional priorities beyond those specified in the voter-approved ballot measure.

As lawmakers debate other possible diversions, the state's plans to finally provide data are tied up in a massive, multi-year technology project. Counties and others, at least in a partial way, are moving more quickly toward fiscal accountability and transparency of MHSA funds. The Commission believes the state must more rapidly develop its own data system to monitor and measure outcomes being delivered by MHSA funding. Proposition 63 backers in 2004 assured voters a high level of statewide oversight for this new revenue stream. Twelve years without definitive data to meet these assurances is hardly what voters expected, and if known, may well have provided a different outcome at the ballot box.

Despite some of these misgivings, the Commission remains hopeful that the many proposals it heard to improve fiscal transparency and accountability for outcomes will lead to necessary improvements. The Commission was most inspired by the stories shared during the site visits by those whose lives have been improved. With better accountability, the Commission also remains hopeful that many more Californians, rather than just some, will receive the help that they need. The Commission respectfully submits recommendations to strengthen the oversight of the Mental Health Services Act and stands ready to assist in this important initiative to improve the health of Californians.

Sincerely,



Pedro Nava
Chair, Little Hoover Commission

CONTENTS

- 5 INTRODUCTION**
- 7 A CONTINUING CHALLENGE: “MUDDLED” LEADERSHIP STILL OVERSEES MHSA SPENDING**
- 12 THE QUESTION REMAINS: WHERE IS THE MONEY GOING?**
- 15 STILL UNKNOWN: IS THE ACT ACHIEVING ITS GOALS?**
- 19 CALIFORNIANS STILL NEED MEANINGFUL WAYS TO PARTICIPATE IN SPENDING DECISIONS**
- 21 COUNTIES NEED MORE WAYS TO SHARE SUCCESS**
- 23 APPENDICES**
- 29 NOTES**

SIDEBARS

- 8 KEY COMPONENTS OF THE MENTAL HEALTH SERVICES ACT**
- 15 QUALITY DATA COULD THWART RAIDS ON MHSA FUNDING**
- 16 MEASURING MHSA OUTCOMES: IT CAN BE DONE**
- 17 IMPROVING DATA COLLECTION, PERFORMANCE MEASURES AND OUTCOMES FOR CALIFORNIA’S YOUTH OFFENDERS**

INTRODUCTION

More than a year after the Little Hoover Commission's first look at the Mental Health Services Act, it decided to conduct a follow-up review and found that many concerns remain unheeded. The Commission launched its initial study of the Act in June 2014 to better understand what happens after voters say yes to a spending plan at the ballot box. Introduced to voters in 2004 as Proposition 63, the Act imposed a 1 percent surtax on the wealthiest Californians to directly fund specific types of mental health programs and services across the state and invigorate a faltering statewide mental health system. Since 2004, the Act has generated approximately \$17 billion for mental health programs and services throughout the state – currently at a rate of \$2 billion annually. These funds now comprise approximately 24 percent of the state's entire public mental health budget.¹

Proposition 63 allowed the Legislature to modify the Act without seeking voter approval for each reform. In the years since, the Legislature has exercised its authority to make significant amendments five times. Early reforms expedited distribution of money to on-the-ground service providers, eliminated the state's upfront review of spending plans and reoriented accountability for expenditures to the counties. Other reforms have expanded the variety of allowable programs or diverted funds for specific, one-time expenditures.

In its last review, the Commission heard many accounts of success, including programs and services for the state's mentally ill that likely would have been unaffordable without Proposition 63 funding. Often these anecdotal successes, however, lacked verifiable data. In its January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*, the Commission voiced concern that as money comes through the MHSA pipeline each year, the state lacks an accountability mechanism to assure taxpayers, voters, and most importantly, mental health care consumers and advocates, that the money is being spent in ways voters intended.

The Commission also found overlapping and sometimes unaccountable bureaucracies and an oversight body lacking “teeth” for enforcement. Stakeholders, and ultimately the Commission, were concerned that the state lacks an organization that can effectively oversee the Mental Health Services Act. The mental health program within Department of Health Care Services is overshadowed by the state's massive Medi-Cal program and, without authority, the Mental Health Services Oversight and Accountability Commission (oversight commission) cannot help counties correct deficiencies in their plans or enforce changes to comply with the law. Recommendations from the Commission's January 2015 report are in Appendix B.

Oversight Hearing and Site Visits

The Commission initiated this follow-up review in May 2016 to gauge progress in addressing the serious concerns raised in its 2015 report. The Commission heard from state agencies responsible for overseeing the act, representatives from county mental health directors and local boards, as well as the Act's authors and numerous stakeholders, including clients, family members and advocates. Hearing participants are listed in Appendix A.

In May and June 2016, Commissioners also visited nine programs funded in part or entirely by the Mental Health Services Act in three counties: San Bernardino, Sacramento and Los Angeles. During these visits, the Commission saw how programs funded by the Act help Californians before they need intensive care, and others recover and reclaim their lives. These visits introduced the Commission to programs that give individuals short respites while getting needed help and others that help people transition from unstable living situations to permanent, supportive housing. Most significantly, the Commission heard directly from Californians whose lives and health are improving as a result of these programs.

Descriptions of programs visited, as well as the voices of some participants, are included throughout this report.

Based on its 2015 report, the information provided at its May 2016 hearing and visits to programs funded by the Mental Health Services Act, the Commission has identified several challenges that persist. Important questions remain unanswered: Who oversees MHSA spending, where does the money go and is the Act achieving its goals? Furthermore, though the Act built-in a stakeholder process for spending plans, Californians do not yet have a clear path for participating in, or question, spending decisions. And though the Act promised opportunities to transform the way mental health services are delivered in California by funding new and innovative programs, the state does not offer counties meaningful ways to share lessons learned. The Commission offers recommendations on pages to come to help the state keep its 2004 promise to Californians.



The Integrated Mobile Health Team, Los Angeles County

The Integrated Mobile Health Team helps clients transition from homelessness into permanent supportive housing, improving their mental health and substance use disorders. Mental health, physical health and substance abuse services are provided by multi-disciplinary staff working as one team, under one point of supervision and operating under one set of administrative and operational policies and procedures, using an integrated medical record/chart. Through a “street medicine” approach, the program staff bring care to its clients wherever they are – whether living in an encampment, a car or on the street. In July 2016, the team received the National Association of County’s Achievement Award. (CSS-funded, formerly INN)

One client explained he joined the program and came off the streets because “I didn’t like the feeling of being worthless.”



Photos by Little Hoover Commission staff and the Integrated Mobile Health Team, Mental Health America of Los Angeles in Long Beach, California.

A CONTINUING CHALLENGE: “MUDDLED” LEADERSHIP OVERSEES MHSA FUNDING

When voters approved Proposition 63 in 2004, they also approved a statewide governance system to administer and oversee new mental health programs funded by the Act. The Department of Mental Health was to take the lead state role in implementing most of the new programs created in the measure, as well as allocate funds for those programs through contracts with counties (The Department of Health Care Services picked up oversight responsibilities for the Act after the Governor and the Legislature dismantled the Department of Mental Health in 2012). A new Mental Health Services Oversight and Accountability Commission also would review county plans for mental health services and approve expenditures for certain programs. The measure layered these additional responsibilities within the existing mental health system and throughout the state’s Welfare and Institutions Code. As such, the Act left intact the responsibilities of other existing agencies, including the Mental Health Planning Council to review, to oversee and review the state’s mental health system.² (Examples of statutory roles and responsibilities for these agencies are included in Appendix C.)

In the years since, the Legislature has amended this system several times, but three state agencies continue to share responsibility for administering and overseeing aspects of the Act. At times, these three entities are required to work together to fulfill their roles – providing technical assistance, designing a comprehensive joint plan for a coordinated evaluation of client outcomes and developing regulations and other instructions to administer or implement the Act.³ State law also assigns specific oversight functions to each:

The Department of Health Care Services (DHCS). The department alone has the authority to enter into performance contracts with counties, enforce compliance and issue administrative sanctions if necessary.⁴ In fiscal year 2016-17, the department received funding from the Mental Health Services Act for 19 full-time equivalent staff for these and other functions related to the Act.⁵

State mental health leaders say the DHCS’ role in overseeing the Act is focused on monitoring and auditing for compliance and providing fiscal and program oversight. In practice, the department’s oversight of the Act appears minimal.

The annual performance contracts the department establishes with each county mental health program are its main tool for program oversight. Department leaders conduct onsite reviews of these contracts every three years, at a rate of about 15-18 counties per year – to ensure compliance with state and federal laws and the terms of the contract between the department and county mental health programs.⁶ The executive director of the oversight commission told Commissioners in May, “the DHCS has profound capacity through its performance contracts to shape these programs.”⁷ However, these performance contracts encompass a broad range of mental health programs and services,



El Hogar Guest House Homeless Clinic, Sacramento County

“The Home” is an entry point for mental health and homeless services in Sacramento County. The facility provides a clinic for homeless individuals and temporary housing for adults 18 and older. Services include comprehensive mental health assessments and evaluations, medications, links to housing and applications for benefits and services. The program used MHSA funds to expand services for client care, such as offering subsidies for housing and dental work. (CSS-funded)

One client, thankful for the help she received through El Hogar explained, “California has so many programs compared to [my experiences in] other states. I wish they could have even 10 percent of what California has. Being able to have housing, dental work and services has been awesome for me.”

of which those funded by the Mental Health Services Act are but one part – and a relatively new one. After the absorbing responsibilities from the Department of Mental Health in 2012, DHCS in fiscal year 2013-14 added questions specific to the Act in its reviews. Currently, the department’s review protocol includes only 17 questions related to the Mental Health Services Act – these take up just eight out of the protocol’s 121 pages.⁸ The department’s deputy director admitted to the Commission that these reviews of the Act are “not very robust.”⁹

To provide fiscal oversight, the department also performs “a desk review” of each county’s annual revenue and expenditure report to ensure accuracy and consistency from year to year. Counties are required to submit these annual reports, identifying MHSA revenues, expenditures and unexpended funds and providing information to evaluate programs funded.¹⁰ However, as of August 2016, 37 counties had submitted reports for fiscal year 2013-14 and just 26 counties had submitted reports for fiscal year 2014-15.¹¹ (A list of each county’s reporting status is included in Appendix D.) For those reports received, the department reviews the balance of unspent funds, reportable interest, revenue received and program expenditure levels, and compares the balance of unspent funds reported in the prior year’s report to ensure they match. The department also reviews the amount of revenue counties report receiving with what the State Controller’s Office says it distributed.¹² However, it does not analyze the data reported in these reports to determine whether counties spent the funds as they proposed.

The department alone holds power to address local shortcomings in implementation of the Act by imposing administrative sanctions such as withholding part or all of state mental health funds from the county and requiring the county to enter into negotiations to comply with state laws and regulations. The department also can refer issues to the courts. The Commission heard testimony from some stakeholders that it is appropriate for the department to serve as the enforcer of the Act. However, when Commissioners asked department officials how they might ensure that bad actors are not continuously getting funding, the deputy director said “there isn’t a requirement on the department that we can point to that says this is our role and responsibility.” Additionally, in a subsequent conversation with Commission staff, the deputy director said that if a county is found out of compliance with the Act, rather than initiating administrative sanctions she prefers to phone the county’s mental health director and prompt them for corrective action.¹³

The Mental Health Services Oversight and Accountability Commission. The Mental Health Services Act established the oversight commission to oversee programs funded by the Act, as well as the state’s systems of care for adults, older adults and children. As such, leaders from the oversight commission view its oversight responsibility broadly, to encompass the whole public mental health system, not just the Mental Health Services Act. “Because [the oversight commission] was created by Proposition 63, people think its role is just

KEY COMPONENTS OF THE MENTAL HEALTH SERVICES ACT

Community Services and Supports (CSS). 80 percent of county funding from the Mental Health Services Act treats severely mentally ill Californians through CSS. Within this component counties fund a variety of programs and services to help people recover and thrive, including full-service partnerships and outreach and engagement activities aimed at reaching unserved populations. Full-service partnerships provide “whatever it takes” services to support those with the most severe mental health challenges.

Prevention and Early Intervention (PEI). Counties may use up to 20 percent of their MHSA funds for PEI programs, which are designed to identify early mental illness before it becomes severe and disabling. PEI programs are intended to improve timely access to services for underserved populations and reduce negative outcomes from untreated mental illness.

Innovation. Counties may use up to 5 percent of the funding they receive for CSS and PEI to pay for new and innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

to oversee the Act. But it’s broader,” one senior official at the oversight commission explained.¹⁴ In addition, state law also assigns the oversight commission specific functions and responsibilities related to the Act, such as receiving all county plans for review, and for approving Innovation programs. In fiscal year 2016-17, the oversight commission received funding from the Mental Health Services Act for 30 full-time equivalent staff to carry out its responsibilities.¹⁵

In its 2015 report, concerned that the DHCS did not consistently exercise its enforcement authority over the Act in a timely fashion, the Commission recommended expanding the oversight commission’s authority to review and approve county MHSA Prevention and Early Intervention (PEI) plans, as it does with Innovation plans. The Commission also recommended the oversight commission be granted authority to respond to critical issues identified in county spending plans and clarify the process by which problems get solved. The intent of that recommendation was not punitive, but to expedite a review process that was, at times, taking DHCS up to two years. Some advocates and stakeholders still believe that the state should reinstate authority of the oversight commission to review and approve county spending plans, as well as statewide projects funded by the Act.¹⁶

In response to the Little Hoover Commission’s recommendation, the oversight commission executive director told Commissioners that he was working to “strengthen the local process, strengthen the boards of supervisors, and [the oversight commission’s] ability to do oversight based on the outcomes.” He said that giving the oversight commission “teeth” could potentially distract his commissioners and staff from other functions and would require them to “to really think differently about how we do our job.”¹⁷ The lack of progress of the oversight commission over the last year even to develop a response to the Commission’s previous recommendation indicates that something else must be done to improve accountability and facilitate achievement toward the Act’s goals.

The Mental Health Planning Council. Among other functions, the planning council reviews program performance of the overall mental health system, including programs funded by the Mental Health Services Act. Also, it annually reviews program performance outcome data to identify successful programs and make recommendations for replication in other areas.¹⁸

State law articulates a role for the planning council in developing plans to address the state’s mental health workforce needs and shortages.¹⁹ In fiscal year 2016-17, the planning council received funding from the Mental Health Services Act for five full-time equivalent staff.²⁰ Mental Health Planning Council officials say it lacks the data it says it needs to assess the strengths of the mental health system overall.



Hacienda of Hope, Los Angeles County

Hacienda of Hope is a short-term respite home run by “peers” – adults who are living with mental illness themselves. The respite program, operated by Project Return, The Peer Support Network, offers support and tools to foster wellness and manage crisis and recovery for up to eight guests in the program’s two-story home. Guests create individualized wellness and recovery plans and connect with local resources for employment, housing and mental and physical health care. Adults 18 and older who are experiencing distress or a life crisis, but who are not in immediate danger or in need of on-site medical treatment are eligible to stay. Typically, guests stay between one and three days. They may stay up to 14 days if additional help is needed. (CSS-funded, formerly INN)

A former client, now peer-advisor said of the program, “This is a hopeful place to go when you don’t have hope, when you are broken.”

Without Direction, Some Oversight Functions Haven't Happened

The state has laws requiring counties to provide a substantial amount of information about the Mental Health Services Act that could be used for evaluation. Counties, for example, submit three-year MHSA program and expenditure plans and annual updates to the oversight commission and the DHCS.²¹ These plans include descriptions of MHSA programs, that if compared with expenditure reports, could be used to ensure counties spent their MHSA dollars as they proposed. Yet, no state agency performs this type of review.

DHCS, when it implements recent legislative reforms, will post online county plans as well as revenue and expenditure reports.²² This reform should improve fiscal transparency, but falls short of ensuring accountability.

The oversight commission does not broadly review information contained in counties' program and expenditure plans to identify compliance issues or compile a statewide picture of implementation of the Act. Currently, oversight commission staff only read counties' plans within the context of reviewing Innovation programs. However, according to its deputy director, the oversight commission plans to build technology to make it easier to analyze the county-submitted reports and compare and contrast information across plans.²³



Palmer Apartments, Sacramento County

Run by Transforming Lives, Cultivating Success (TLCS), the Palmer Apartments offer short-term housing for up to 48 adults experiencing homelessness and psychiatric disability. The program provides a safe, hospitable alternative to shelters and access to permanent housing within 30 days once income is secured. Longer-term temporary housing also is available for those awaiting openings in MHSA-financed housing developments. Clients and staff work collaboratively to break the cycle of homelessness during average stays of six to eight months. (CSS-funded)

Reflecting on his experience, one client said "This is the first step for me being who I am. These people give us hope and from here, I'm learning how to live again."

State law does not require any state agency to review, analyze and summarize information contained in all of the county MHSA program plans and ensure the counties are spending the MHSA funds as they said they would. Perhaps it should.

Multiple Agencies, But Who is Accountable?

"Individually, each of the entities – the oversight commission and department of health care services – is very clear about their own responsibilities as set in law," Josephine Black, Chairperson, and Jane Adcock, Executive Officer, of the California Mental Health Planning Council wrote in testimony to the Commission. "However, when taking a global look, the roles are muddled resulting in divided (and weakened) leadership for key aspects of the public mental health system and no clear designation of authority. Who is to hold the system accountable? Who is to hold the oversight entities accountable?"²⁴

Advocates, stakeholders and others told the Commission they remain confused and dissatisfied with the diffusion and overlap of responsibilities at the state. They are still concerned that no one is accountable for overseeing the Act and systematically and comprehensively evaluating its outcomes. Questions remain about which agencies are ultimately responsible for ensuring the promises made to voters are kept:

- Is it the responsibility of the oversight commission to focus its oversight and evaluation efforts specifically on programs funded by the Mental Health Services Act, or on the broader public mental health system? And if the oversight commission's role is broad, how does that differ with the planning council?
- Is it the responsibility of the department to investigate whether county spending plans align with actual expenditures or is this a function of the oversight commission?
- Which agency is responsible for ensuring the state's progress toward achieving the transformational vision of mental health services proposed to and approved by voters in 2004?
- Which agency is ultimately responsible for determining how to evaluate the programs funded by the Act – is it the oversight commission, the department, counties or the Health and Human Services Agency?

- Which agency is best situated to enforce compliance with the Act and to hear and address concerns raised by consumers, family members, stakeholders and advocates if and when issues arise at the local level?
- When problems are identified by the oversight commission or the planning council, how do either of these entities ensure corrective action is taken by the department which has authority to act?

When looking for accountability to the Mental Health Services Act, it's difficult to see clearly because a tangled web of organizations with conflicting and overlapping oversight responsibilities is tasked with the job. Some argue that this diffusion makes sense: the Act is but one funding stream for a diverse and complex mental health system. But who is truly accountable? When asked by Commissioners, former State Senator Darrell Steinberg and co-author of the Mental Health Services Act, said ultimately, it's elected leaders – the Governor and the Legislature.²⁵ At some juncture, policymakers may question this division of responsibilities and consider whether California needs all three organizations. In the meantime, despite past clarifications, more must be done to further articulate the roles and responsibilities of the various state agencies that administer, oversee and enforce the Act. Voters enacted the measure with the expectation of oversight, putting a strong onus on the state to ensure that these dollars – specifically – are spent as voters intended and produce the outcomes promised. The state should notify any non-compliant county behavioral health department and board of supervisors with a written notice including a deadline and specific remedy to achieve compliance and these written notices should be prominently published on a state website. To ensure compliance, the state should withhold money from non-compliant counties – as current law allows – and redistribute this money to other counties that are complying with the Act. The Legislature should enhance current law to make this withholding mandatory after one or more formal written notices regarding non-compliance are sent to the county.

Recommendation 1: The Legislature should further clarify the roles and responsibilities of the state agencies responsible for administering, overseeing and enforcing the Mental Health Services Act.

Specifically it should:

- ***Clarify expectations for the scope of responsibilities of the department, oversight commission and planning council and define the separate roles of each in ensuring the Mental Health Services Act funds are used as voters intended.***
- ***Call on the entity charged with enforcement, currently the Department of Health Care Services, to identify the mechanism by which it will enforce the Act. The entity should identify metrics it will apply to evaluate county performance with potential consequences. Repeated poor performance should result in mandatory redistribution of money to compliant counties.***

THE QUESTION REMAINS: WHERE IS THE MONEY GOING?

To better answer basic questions about the statewide allocation and use of Mental Health Services Act funds, the Commission in 2015 recommended the Mental Health Services Oversight and Accountability Commission post meaningful financial information on its website. At a minimum, the Commission suggested, this should include a fiscal snapshot of overall and current year revenues and allocations by program component areas. It also should include information on how the state spends MHSA state administration funds.

Since the Commission’s last review, the oversight commission launched an updated website which includes some financial elements recommended by the Commission. Among them: a breakdown of the cumulative MHSA revenue reported since the Act passed in 2004.²⁶ The website also includes a placeholder page for county-submitted reports and financial evaluation reports. When posted, the public will find important information about the Act in one centralized location.²⁷ These, and planned improvements described below, are steps in the right direction. But, more can be done to help voters, taxpayers and mental health advocates, consumers and their families understand how money from the Act is used locally and statewide.

Though some counties make financial information about their MHSA expenditures readily available, the Commission heard from stakeholders and other members of the public that in some communities it is still difficult to track how MHSA funds are spent. (Counties receive about 95 percent of the dollars generated by the Act each year in amounts based on a formula established by the Department of Health Care Services. In fiscal year 2016-17, counties received approximately \$1.9 billion.²⁸)

“Mental health advocates, providers, and stakeholders alike, all want to know where the money is going. Most counties are not transparent with MHSA growth revenue and additional resources are not trickling down to the providers who offer mental health services,” Matthew

Gallagher, program director for the California Youth Empowerment Network, told the Commission. “So where is all the money going?”²⁹

New Tools Promise Easier Access to Local Financial Information

Some suggested a state entity should be made responsible for dispersing the information in a user-friendly format online. Also needed: a reporting process that quickly makes the information public.³⁰

A new fiscal transparency tool could show local MHSA expenditures online. According to its executive director, the oversight commission built the tool using data that counties must submit to the state in annual revenue and expenditure reports. The tool, he said, can show the distribution of MHSA funds to each county by component, identify how much has been spent and how much remains unspent, and show cumulative balances for each component of the MHSA. Plans to showcase the tool on the oversight commission’s website have stalled while addressing county



One Stop Transitional Age Youth Center, San Bernardino County

The one stop center – one of four in the county – provides a range of drop-in services for youth ages 16-25 with, or at risk of, mental and emotional issues. The goal of treatment: to offer employment assistance, educational opportunities, shelter housing, counseling and group activities to help clients become independent, stay out of the hospital or higher levels of care, reduce involvement in the criminal justice system and reduce homelessness. Because of disproportionate overrepresentation in the justice system and foster care system, the program specifically targets Latino and African-American youth. The county’s Probation and Children and Family Services, and other community groups, act as program partners. (CSS-funded)

concerns about the validity and reliability of the fiscal data on which it is built.³¹ Despite setbacks, plans are in place to launch the tool by October 2016.³²

The No Place Like Home initiative, a legislation package signed by Governor Brown in July 2016, established a new program for addressing homelessness and also included accountability measures. The legislation requires counties to certify the accuracy of their revenue and expenditure reports – and reiterates that the Department of Health Care Services may withhold Mental Health Services Funds for counties that fail to submit timely reports. Additionally, the legislation requires the department and the oversight commission to post county revenue and expenditure reports online.³³ When implemented, this will help fulfill one of the Commission’s previous recommendations.

The Department of Health Care Services intends to begin posting these reports online no later than mid-September 2016, beginning with reports from fiscal year 2014-15.³⁴ It is clear to the Commission that making reports publicly available will create additional pressure on noncompliant counties to submit their reports, as would, at a minimum, posting each county’s submission status.

“State level reporting does not allow for review of where the funding is going besides the full services partnerships, and also does not provide meaningful comparison of the relative costs and results of each FSP program. We don’t know who or what produces the best results and how the answers might vary based on age, sex or ethnicity.”

Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California³⁵

Additionally, proposed legislation, if signed by the Governor, would make it easier for Californians to understand how counties, alone and collectively, use MHSA funds. With this information, local decision-makers, advocates and stakeholders may be able to identify best practices in other counties and better inform their own spending decisions. Specifically, the measure, AB 2279 (Cooley), would require the DHCS, by July 1, 2018, to analyze data submitted by counties in their revenue and expenditure reports and annually produce a summary of revenues, expenditures and funds held in reserve. By requiring the department to make

readily-available data about revenues and expenditures by component, by county, the legislation also would implement Commission recommendations.

Accomplishments of State Administrative Funds are Still Difficult to Track

Though the bulk of Mental Health Services Act funds go directly to counties to spend on programs and services, 5 percent goes each year to state administration of the Act. As the tax base grows, so, too, does the state’s share. In fiscal year 2016-17, the Act is expected to generate approximately \$102 million for state administration, about \$15 million more than during the Commission’s last review.³⁶

State law guides how this portion of funds is spent. The Mental Health Services Act, as presented to voters in 2004, directed the California Mental Health Planning Council and the Mental Health Services Oversight and Accountability Commission to use the state administration funds “to implement all duties pursuant to the [MHSA] programs.” The Act further specified that the state administration funds be used for two purposes:

- “assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services” and
- “ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth [in the Act].”³⁷

Current law gives these funds to five state agencies – the Department of Health Care Services, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, the Office of Statewide Health Planning and Development and the Department of Public Health – as well as any other state agency that implements MHSA programs. In fiscal year 2016-17, these five agencies received approximately \$22 million to support 72.5 positions and provide oversight of the Act. (Of this, the DHCS, planning council and oversight commission together received about \$15 million and 54 positions). Additionally, eight other agencies received funding for 23.5 positions and a myriad of programs ranging from supporting student mental health, conducting outreach to service members,

funding regional centers that develop innovative PEI projects and administering various grants.³⁸

The Commission, concerned that there is insufficient oversight of this large and growing pot of money, recommended in 2015 the oversight commission bolster its oversight of the state administration funds and provide policymakers with analysis, beyond the straightforward fiscal accounting provided by the Department of Health Care Services. The annual MHSA Expenditure Report, produced by the DHCS, provides a high-level overview of overall MHSA revenues and expenditures, as well as a brief description of how and where the state administration funds are disbursed. It does not offer an analysis, however, of how the various state entities use the funds to achieve MHSA goals.

Currently, decisions about the allocation of state administration funds are made through the regular budget process. The Department of Finance issues policies and procedures for departments to propose budget changes – including proposals for departments to access MHSA funds. Rules prevent the oversight commission from consulting on MHSA-related budget change proposals. However, the oversight commission does consult with the Department of Finance, the Legislative Analyst’s Office and legislative committees on specific budget proposals.³⁹ For example, the oversight commission currently is working with the Department of Finance and the Legislature to make it easier to understand how much is available in unspent state administrative funds.

The state needs to ensure that its 5 percent share of MHSA funds are spent appropriately. Someone must be responsible for asking: is it spent on purposes defined by the Act and what is it achieving?

During the Commission’s last review, the Mental Health Services Oversight and Accountability Commission’s financial oversight committee had begun inviting entities that receive part of the MHSA state administrative funds to report how the money is used. These presentations were helpful for decision-makers and stakeholders to better understand how these funds were being used and what they were accomplishing. However, the last time the committee heard a presentation from one of the state departments receiving funds was in November 2014.⁴⁰

The former Department of Mental Health coordinated interagency partnerships among the various entities that received MHSA state administration funds. It also established memorandums of understanding with receiving entities that clarified expectations and responsibilities for use of the MHSA funds.⁴¹ This type of oversight is needed again. To strengthen oversight of the ever-growing amount of state administrative funds and make it easier to analyze and evaluate their uses, the oversight commission should regularly analyze how state administrative funds are spent and what they achieve. Findings could help legislators and policy leaders better determine the successes of state programs funded with MHSA dollars, and make more informed decisions about spending increases or cuts as the fiscal climate demands.

Recommendation 2: The Governor should approve legislation, AB 2279 (Cooley), to make it easier for Californians to see how and where their Proposition 63 tax dollars are being spent.

Recommendation 3: The Department of Health Care Services should immediately begin posting online the MHSA Revenue and Expenditure reports it has available, instead of waiting for all counties to submit all reports.

Recommendation 4: The state must ensure MHSA state administrative funds are spent properly.

- ***The Mental Health Services Oversight and Accountability Commission’s financial oversight committee should reinstate presentations from departments receiving a portion of the state administrative funds, analyze expenditures and compile an annual report for consideration of the full oversight commission.***
- ***The oversight commission should share its findings with the Department of Finance, Legislators and the public.***

STILL UNKNOWN: IS THE ACT ACHIEVING ITS GOALS?

Despite compelling claims that the Mental Health Services Act has transformed mental health services in communities across California, the Commission noted in its 2015 report that the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars. In large part, this is due to the lack of robust data that can show policymakers and mental health leaders what interventions are working in specific populations.

“Data is not just esoteric. It provides necessary information to share with policymakers who may not believe that there is any real solution to the state’s homelessness crisis, or to help people stop cycling out of emergency rooms when they need immediate mental health assistance,” former state Senator Darrell Steinberg, co-author of the Act, told the Commission.⁴²

Josephine Black, Chairperson, and Jane Adcock, Executive Officer of the Mental Health Planning Council echoed a similar sentiment about the importance of mental health data: “We have many individual stories of success and they are extremely important and put a human face on the progress. However, data is the fundamental and universally-accepted evidence of progress.”⁴³

MHSA Data Effort Lost in Broader Mental Health Data System Fix

To tell a successful Proposition 63 story, the Commission in 2015 urged state mental health leaders to improve online access to existing MHSA information, plans and reports and showcase more model programs and best practices. The executive director of the oversight commission said he plans additional upgrades to the organization’s website over the next three to five years to map programs by type, geography and outcomes.⁴⁴ This is a promising vision.

The Commission also recommended the state develop a comprehensive, statewide mental health data collection system. As a first step, the Commission called on the

oversight commission and the Department of Health Care Services to develop a plan and timeline for a data collection system capable of blending information for MHSA programs and other state behavioral and mental health programs.

Since the Commission’s 2015 review, the state has continued with long-term plans to modernize legacy data systems for its mental health and alcohol and drug abuse programs. The proposal: a seven-year, multi-phase, multi-million dollar project to upgrade the state’s existing mental health data systems and streamline data collection. The oversight commission in 2015 funded the Department of Health Care Services to prepare a preliminary plan for this upgrade. As of July 2016, the department is awaiting approval from the Department of Technology to submit the preliminary plan to the federal

QUALITY DATA COULD THWART RAIDS ON MHSA FUNDING

At its May 2016 hearing, the Commission heard testimony from advocates and members of the public that recent legislative proposals to steer MHSA funds to new uses, while well-intended, may weaken the ability of counties to care for the mentally ill. Some said these proposals simply target the Mental Health Services Act as a “go to” funding source for ever-expanding programs and will lead to “theft” from the Act in future budget years.⁵⁶ During the 2015-16 legislative session, members proposed several bills to redirect Mental Health Service Act funds, including approximately \$130 million annually in bond interest payments and more than \$7 million dollars in one-time expenditures. These funds were proposed to construct permanent, supportive housing for chronically homeless people with mental illness, expand on-campus mental health services at colleges and provide funds for administration and technical assistance for specific programs.⁵⁷

Centers for Medicare and Medicaid Services.⁴⁵ Next steps include another plan to implement the project, then issue a bid for vendors to design, develop and build the new system by June 2021.⁴⁶ Cost estimates are not yet available. But the initial planning phase will cost nearly \$3 million, with the federal government picking up most of the tab.⁴⁷

While recognizing that a process to transition and modernize legacy data systems is complex, the Commission has strong reservations about the current data modernization proposal. It is unreasonable to wait nearly two decades for the state to collect and report data about the Proposition 63 funding stream. Government agencies across the nation – at the federal, state and local levels, are demonstrating that new approaches to data collection and sharing can cost less and be implemented faster than efforts to maintain outmoded technology. For example, the California Department of Social Services in 2015 partnered with Code for America and the federal government’s tech innovation team, 18F, to change its approach to procuring technology for a new Child Welfare System. Instead of issuing a massive contract for the project as a whole – traditionally a costly approach with low success rates – the department will build the new system in a series of projects focused on developing and delivering user-centered services and open source practices.⁴⁸ The Commission highlighted similar efforts in its 2015 report, *A Customer-Centric Upgrade for California Government*.

Meanwhile, Counties Initiate Their Own MHSA Data Collection Projects

Some counties individually have used MHSA money to develop local data systems to track outcomes. Los Angeles County built an application to measure MHSA outcomes and now produces a quarterly newsletter highlighting outcomes for participants in MHSA-funded programs. Debbie Innes-Gomberg, district chief of the Los Angeles County MHSA Implementation and Outcomes Division, also told the Commission the value of the data is “not just about saying that MHSA has made an impact. It’s about making decisions using that data, learning from that data and improving the quality of our services.”⁴⁹ These reporting practices should be a model for other counties that still lack capacity to report outcomes of MHSA-funded programs.

In the absence of a statewide mental health data system capable of reporting MHSA program outcomes, the County Behavioral Health Directors Association initiated its own data collection project in 2014, association executive director Kirsten Barlow told Commissioners in May. The Measurement, Outcomes and Quality Assessment (MOQA) project enables counties to report collective results of some MHSA programs using data counties already collect. Specifically, it aims to create uniformity in outcome reporting across different types of MHSA-funded programs.⁵⁰

MEASURING MHSA OUTCOMES: IT CAN BE DONE

Los Angeles County now has a decade worth of data for some MHSA-funded programs, which it uses to guide decisions about where to refine or expand services countywide. Using money from the Act, Los Angeles County in 2006 built a data system to capture outcomes of clients enrolled in full-service partnership (FSP) programs – one type of program funded under MHSA Community Services and Supports (CSS). In the years since the county has twice expanded the system to capture outcomes from field capable clinical services (FCCS), another CSS-funded program, as well as Prevention and Early Intervention (PEI) programs.

Through its Outcome Measure Application, the county records and monitors clients’ progress and response to services and reviews the impacts that programs have on clients’ welfare. For example, data from the system shows that while in FSP programs, clients experience fewer hospitalizations, less homelessness, reduced incarceration and fewer emergency events. Children improve their grades, more adults live independently and some gain employment for the first time. Clients in FCCS programs spend more time engaging in meaningful activities, such as working, volunteering or participating in community activities. PEI clients show dramatic reductions in symptoms; they are less depressed, less anxious, parents report fewer behavior problems and fewer symptoms related to trauma. Reports produced from the data also are shared with providers to encourage them to think about how they use and analyze outcome data in their own programs, county staff said.⁵¹

The project allows counties to report on outcomes through an online portal, supported and maintained by the California Institute for Behavioral Health Solutions. Currently, the database is set up only to collect outcome data from full-service partnership programs – one of the largest types of programs funded with MHS Community Services and Supports dollars. Common data elements for these programs include average percent of clients re-hospitalized within 30 days, reduction in homelessness, psychiatric hospitalizations and incarcerations for adults and reduction in trauma symptoms for children. The association is developing additional outcome measures for Prevention and Early Intervention programs.⁵² The MOQA database was built with funding from the Department of Health Care Services.

With compiled data, the California Behavioral Health Directors Association, in partnership with the Steinberg Institute, has released two easy-to-understand reports since 2015 showing that participants of county full-service partnership programs help people recover and get better when they have the right kind of support. (The Steinberg Institute is a statewide organization launched in 2015 to advance sound public policy and inspire leadership on mental health issues.) Among 25,418 children and adults served between 2013 and 2014, homelessness and emergency shelter use declined, as did arrests, psychiatric hospitalization and mental health emergencies. Most children did better in school and

some adults were able to find jobs after one year in a program.⁵³ The process also has improved data collection and reporting processes and increased use of data to inform best practices and administrative decisions.⁵⁴

Additionally, reports about the California Mental Health Services Authority's (CalMHSA) statewide Prevention and Early Intervention programs demonstrate reduced stigma and discrimination around mental illness. Investments also have educated many Californians about how to intervene with people at risk for suicide. CalMHSA, created by counties in 2010, uses MHS funds to implement statewide Prevention and Early Intervention services.⁵⁵

These reports and others demonstrate outcomes for portions of programs funded by the Mental Health Services Act. They begin to paint a statewide picture of what the Act has achieved and are critical for providing policymakers with evidence of how the programs are working. These types of reports demonstrate the type of statewide analysis and reporting that should be the norm for all programs funded by the Act. In the long term, it is not sustainable nor prudent to rely on other organizations to do the work that should be done by the state in its oversight capacity.

The State Still Needs to Improve MHS Data Collection

State leaders must immediately build on the counties' MOQA project to produce statewide MHS outcome reports.

IMPROVING DATA COLLECTION, PERFORMANCE MEASURES AND OUTCOMES FOR CALIFORNIA'S YOUTH OFFENDERS

California's juvenile justice data system has lingered without a significant state investment in data modernization for more than two decades. Among its challenges: outdated technology that cannot be upgraded, inability to track important case and outcome information and a lack of performance outcome measures, poor transparency and availability of statewide information, and, fractured data collection and reporting responsibilities among different state agencies and lack of integration with county-level data systems.⁵⁹

To address long-standing concerns about the state's lack of a juvenile justice data system, the Legislature in 2014 established a working group to help clarify what would be needed for the state to build capacity to collect and use juvenile justice data to support evidence-based practices and promote positive outcomes for the children and youth who move through the system. Staff from the Board of State and Community Corrections supported the working group by coordinating meetings, taking notes and drafting reports. After more than a year of meetings, research and deliberation, the working group released a report offering recommendations to improve and modernize the data system, while addressing concerns related to the cost of replacement technology as well as the need to create a system that leverages the infrastructure of existing county data systems.⁶⁰

State mental health leaders, with relevant stakeholders, should collectively identify indicators that will show progress toward reducing the negative outcomes from untreated mental illness. Defined by the Act, those include suicide, incarcerations, school failure or dropping out rate, unemployment, prolonged suffering, homelessness, and removal of children from their homes. Evaluation efforts by the counties show that reporting on these types of indicators is already possible for some components of the Act.

“We wonder whether mental health disparities are being reduced. But because of the lack of data, no one can really prove anything beyond anecdotal examples.”

Stacie Hiramoto, Director, REMHDCO⁵⁸

State leaders also should collect data to better understand who is being served. Throughout the Commission’s last review and again at its May 2016 hearing, advocates, stakeholders and members of the public voiced concerns that the state still cannot account for the number of people served by the Act, nor produce basic demographic data. Of particular importance, many said, is reporting data on racial, ethnic and other minority communities so the state can better understand how the Act is reducing disparities in services and guide future spending decisions. They said statewide outcome measures should include demographic information about who benefits from the Act, including their ages, gender, racial and ethnic background and language spoken.

Additionally, state mental health leaders should acknowledge the anxiety that the collection of outcome data can cause. They should emphasize the use of data to improve services and promote best practices, not to sanction poor performers. To ease the anxiety, representatives of those who will collect and use the data should be included in the process to clarify what the state must collect to oversee the Mental Health Services Act. The state’s work to build a juvenile justice data system offers a model to begin a conversation about building an appropriate outcome data system for MHSA-funded programs.

The Department of Health Care Services has started a workgroup to identify common ways counties measure and report MHSA and other behavioral health data to the state and to consider what doesn’t need to be provided

to the state. Membership includes key staff from the oversight commission, Mental Health Planning Council and counties. However, it is not clear from conversations with participants whether this group meets regularly, has an ultimate purpose for meeting, and whether the meetings or meeting materials are available to the public.

The state should leverage the momentum spurred by local data collection efforts, as well as burgeoning coordination among state agencies to review mental health data requirements in order to build a modern, Web-based data collection system to report outcomes from MHSA-funded programs.

Recommendation 5: Before proceeding further with the data modernization project, the Department of Health Care Services should immediately consult with civic technologists and data experts to refine and streamline its approach to modernizing the state’s mental health data collection system.

Recommendation 6: The Legislature should establish a Mental Health Services Act (MHSA) data workgroup within the Department of Health Care Services to build on existing county MHSA data collection efforts and develop and support a statewide MHSA database. The workgroup should:

- ***Be comprised of representatives from entities who collect and use mental health data at the state and local levels, stakeholders as well as technology experts and should be supported by department staff.***
- ***Define the statewide outcomes needed to evaluate the MHSA, identify whether existing data collection efforts are sufficient for reporting and articulate the technological needs for such a data collection system. If existing data is not sufficient, the workgroup should recommend how counties and providers might collect the additional data without creating undue work or redundancies for counties and providers.***
- ***Specify how demographic data will be collected, including age, gender, racial and ethnic background and language spoken.***

CALIFORNIANS STILL NEED MEANINGFUL WAYS TO PARTICIPATE IN SPENDING DECISIONS

The Mental Health Services Act established a process – and allocated resources – for stakeholders to participate in county decisions about how to spend MHSA funds. The Act specifically calls for stakeholder involvement in developing counties’ three-year program and expenditure plans and annual updates. It also requires counties to “demonstrate a partnership with constituents and stakeholders through the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation and budget allocations.”⁶¹ These provisions codify a central and ongoing role for stakeholders in determining how and where counties should invest their MHSA resources.

However, in this review and the last, the Commission heard that some counties fall short in including stakeholders in meaningful decisions. “Proposition 63 included specific requirements that county spending plans be developed through a stakeholder process.



Boulevard Court Apartments, Sacramento County

Operated by Mercy Housing California, the Boulevard Apartments offer a low-income housing program for homeless people with special needs. Using MHSA funds, the program renovated a formerly dilapidated motel in a high-need neighborhood into a campus with 74 studio and one-bedroom units that offer residents supportive services such as health care education, financial literacy and community involvement. With stable housing in a supportive environment, residents can focus on successfully managing their individual disabilities. (CSS-funded)

“I like being here,” one participant said. “The best thing is that it is affordable for me and there’s a doctor onsite. Otherwise, it takes two to two and a half hours transportation time by the bus [to get to a doctor].”

Counties have complied with the state requirements,” Rusty Selix, MHSA co-author told Commissioners. “Unfortunately that guidance has missed the mark by measuring how many people attended meetings and how many groups the counties reached out to.” He explained that counties are not required to describe how the funds are proposed to be spent compared to how they are actually spent. Nor are they required to have meaningful discussions that welcome stakeholder views before and after spending decisions are made.⁶² Some stakeholders say spending decisions seem to be made before they are asked to provide input, and that their input is “window dressing.”⁶³

“The approach to community engagement matters,” Stacie Hiramoto, director of the Racial and Ethnic Mental Health Disparities Coalition, told Commissioners. “A lot of times, counties have a big meeting at a big public place. For many people in underserved communities it’s not our culture to come out in public. And, in some of our communities, the stigma regarding mental health issues is actually more acute.” Ms. Hiramoto and others also explained there can be language or cultural barriers that impede participation, as well as scheduling barriers that make it difficult for workers to attend meetings during regular business hours.

To make it easier to participate in MHSA planning efforts, stakeholders suggested counties partner with community groups or trusted leaders to figure out the best ways to approach certain cultural groups and show respect for their distinct values. With the help of these partners, counties could advertise meetings in different languages and hold discussions in smaller venues where people feel comfortable. Scheduling meetings in the evening or on weekends also could help working families participate.⁶⁴ Additionally, they suggested counties – as well as the state – establish advisory committees that involve consumers, family members and representatives of underserved communities in decisions. Many of these suggestions echo recommendations from various groups, including the Mental Health Planning Council,

the California Stakeholder Process Coalition and the oversight commission to fortify stakeholder engagement in implementation of the Act.⁶⁵

Additionally, clients and advocates suggested the state strengthen the process for stakeholders to report issues and concerns at the local and state levels. Several told Commissioners they are unsure where they should turn when they identify problems with the local planning process and program implementation. Some said they fear retaliation for speaking out against spending decisions or registering a complaint with the local process. Others said that even when local leaders articulate a plan of correction, there is no oversight by the state to ensure that what was promised is done.

In its triennial performance audit of counties, the Department of Health Care Services reviews whether counties have an issue resolution process for the Mental Health Services Act and that they maintain a log of all issues received and the dates they were resolved. The department does not, however, review the quality of these processes nor does it assess whether they are sufficient for capturing and responding to concerns.

In response to concerns about the adequacy of the issue resolution process, the oversight commission has begun a formal project to review the process and identify opportunities to clarify and strengthen ways for stakeholders to raise concerns and for those

concerns to be addressed, the oversight commission’s executive director told the Commission. The Commission commends this effort and encourages the oversight commission to develop tools and templates to improve the local issue resolution process, including making it easier for clients, advocates and others to learn how to engage and how and where to elevate their issue to the state, if necessary.

Recommendation 7: The Mental Health Services Oversight and Accountability Commission should provide guidance to counties on best practices in engaging stakeholders in MHSA planning processes, and offer training and technical assistance if necessary. Additionally, the oversight commission should develop standards and a template for counties to create consistency in reporting and responding to concerns about the Mental Health Services Act. The oversight commission and the Department of Health Care Services should clarify the process for elevating issues or concerns related to the Mental Health Services Act from the local level to the state.



Navigation Teams, Los Angeles County

Eight navigation teams work regionally across the county to help individuals and families access mental health and other supportive services. Navigation Team members help quickly identify available services tailored to a client’s cultural, ethnic, age and gender identity, and follow up with clients to ensure they received the help they need. Team members also build an active support network through partnerships with community organizations and service providers and map availability of local services and supports in the area. (CSS-funded)

A team member described the program as concierge mental health services – “navigators help people directly link to the services they need.”

COUNTIES NEED MORE WAYS TO SHARE SUCCESS

The Mental Health Services Act provides Innovation funds for counties to experiment with promising practices that have not yet proven effective. This financial commitment allows local communities throughout the state to become testing grounds for new and innovative mental health programs and practices. Brought to scale, successful programs could transform the way mental health services are delivered in the state. However, key to that transformation is the ability of local mental health leaders, providers and clients and their families to regularly share information and lessons learned about what's working, what's not and why.

Counties and providers currently have several venues to share best practices and lessons learned. For example, Mike Kennedy, Sonoma County's Behavioral Health Division Director, told the Commission in September 2014 that counties can learn about successful approaches in other counties through the County Behavioral Health Directors Association and its subcommittees, conferences and forums.⁶⁶ The associations' MHSa committee also holds monthly conference calls or meetings to share information about programs funded by the Mental Health Services Act.



The Transitional Age Youth Behavioral Health Hostel – The STAY, San Bernardino County

The hostel offers a short-term crisis residential program for up to 14 Transition Age Youth between ages 18 to 25 who are experiencing an acute psychiatric episode or crisis and is the first crisis residential treatment facility in the county. Services are culturally and linguistically appropriate, with a particular emphasis on diverse youth (African American, Latino, LGBTQ, etc.) as well as former foster youth or youthful offenders. The hostel is primarily peer run by individuals representing the county's diverse ethnic communities and cultures. (INN-funded)

Additionally, the department, oversight commission and individual counties occasionally contract with the California Institute for Behavioral Health Solutions to develop training programs on evidence-based practices, hold conferences and policy forums, among other consultative activities. The nonprofit institute, established in 1993, helps health professionals and others improve the lives of people with mental health and substance use challenges. When the Mental Health Services Act was initially passed, the Department of Mental Health contracted with the institute to help counties develop and run full-service partnership programs. With input from state and local mental health leaders, providers, clients and family members, the institute developed toolkits to help providers implement full-service partnership programs, ensure ongoing quality improvement and improve access to care for unserved and underserved ethnic and cultural groups.⁶⁷ The institute has not yet been approached to coordinate similar training around successful MHSa Innovation programs.⁶⁸

Despite existing efforts to collaborate, the Commission heard from stakeholders that more is needed and suggested the state could play a key role in fostering information sharing and by providing additional technical assistance. At each county visited, the Commission heard providers say in various ways, "I'm not sure if other counties have a program like this."

One member of an award-winning MHSa-funded Innovation program in Long Beach lamented, "I've been thinking about putting together a training program because no one seems to have anything like this. But I just haven't found the time."

Another provider – a "navigator" who links individuals and family members to appropriate mental health services, and provides referrals and responds to pleas for help – said she wishes for a way to "connect the connectors." She explained that while she and the other "navigators" are familiar with the various programs in her

county, it would be helpful also to know what is available elsewhere. “It would be great to have conferences, more provider-to-provider learning opportunities,” she said. “If we don’t see anything outside our county, we’re not learning.”

The state could spread promising practices across communities and county boundaries by collecting information from successful Innovation programs and working with providers to develop training programs and share best practices.

The oversight commission has the statutory authority to establish technical advisory committees, employ technical assistance staff and other appropriate strategies as necessary to perform its duties.⁶⁹ But, according to its executive director, “the oversight commission does not currently have the staff to provide technical assistance and training on how innovation can be transformative.” Nor does it “currently have the capacity to fully disseminate information on the lessons learned through innovation investments.”

The oversight commission requested, and received in the 2016-17 budget funding for additional staff to better document how counties are innovating, what has worked and why. The oversight commission plans to develop tools and provide technical assistance around Innovation programs, as well as disseminate best practices. It also intends to reach out to partners in the business community, universities, foundations and federal

agencies, as well as counties and service providers, to leverage innovation as a strategy for transformational change, the executive director said.⁷⁰ Again, this is a promising vision, but more must be done to ensure that counties get the help they need to leverage best practices across the state, fulfilling one of the original intentions of the Mental Health Services Act.

To scale up promising MHPA-funded Innovation programs, mental health practitioners need more opportunities to learn from each other about what’s working well so that successful programs can be replicated. As part of its oversight responsibilities, the oversight commission should prioritize fostering the transformational potential of the Mental Health Services Act’s Innovation programs.

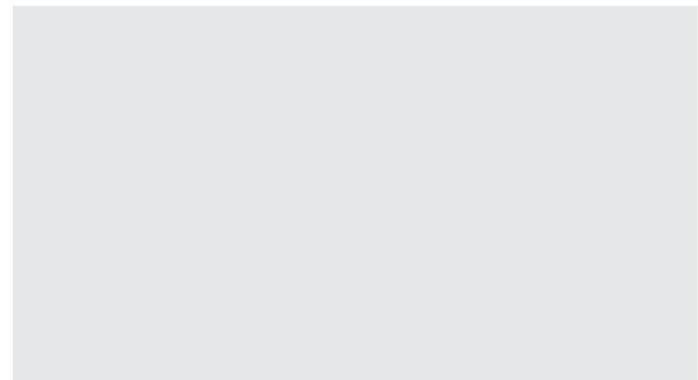


Photo by Little Hoover Commission staff at the Crisis Respite Center – Transforming Lives, Cultivating Success in Sacramento, California.



Crisis Respite Center, Sacramento County

Since opening in December 2013, the Crisis Respite Center provides crisis intervention services that reduce law enforcement calls and unnecessary emergency room visits. The program stabilizes adults experiencing mental health crises with 24/7 drop-in services in a warm and supportive setting. The program provides a stable, supportive environment to help “guests” explore their crises with a solution-oriented mindset. (CSS-funded, formerly INN)

A client reflected, “Here I had the chance to settle down and think straight *because* I felt safe. I had the chance to regroup coming here.”

APPENDICES**Appendix A: Public Hearing Witnesses**

***Public Hearing Revisiting the Mental Health Services Act
May 26, 2016***

Jane Adcock, Executive Officer, California Mental Health Planning Council

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition

Kirsten Barlow, Executive Director, County Behavioral Health Directors Association

Debbie Innes-Gomberg, District Chief, Los Angeles County MHSa Implementation and Outcomes Division

Karen Baylor, Deputy Executive Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Daphne Shaw, Councilmember, California Mental Health Planning Council

Phillip Deming, Chair, San Diego County Behavioral Health Advisory Board

Rusty Selix, MHSa Co-Author and Executive Director of Policy and Advocacy, Mental Health America of California

Toby Ewing, Executive Director, Mental Health Services Oversight & Accountability Commission

Darrell Steinberg, Former Senate President Pro Tem and Founder, Steinberg Institute

**Appendix B: Recommendations from the Little Hoover Commission's January 2015 report,
*Promises Still to Keep: A Decade of the Mental Health Services Act***

Recommendation 1: The Legislature should expand the authority of the Mental Health Services Oversight and Accountability Commission. Specifically, it should:

- Strengthen the ability of the state to conduct up-front reviews of the more controversial programs funded by the act before funds are expended by requiring the oversight commission to review and approve county Prevention and Early Intervention plans annually, as it currently does for Innovation plans.
- Refine the process by which the state responds to critical issues identified in county three-year plans or annual updates to ensure swift action. Empower the oversight commission to impose sanctions, including the ability to withhold part of the county's MHSA funds, if and when it identifies deficiencies in a county's spending plan. Decisions of the oversight commission should become mandatory unless they are overturned by the Department of Health Care Services within a reasonable period, such as 60 days.

Recommendation 2: To provide greater oversight and evaluation of the state administrative funds, the oversight commission should annually develop recommendations for and consult with the Department of Finance before the funds are allocated.

Recommendation 3: To make MHSA finances more transparent and make it easier for voters, taxpayers and mental health advocates, consumers and their families to see how and where the money is spent and who benefits from its services, the Mental Health Services Oversight and Accountability Commission should add to and update material on its website to include:

- MHSA revenues, by component and annual allocations, and the cumulative total revenue since voters approved the act.
- Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.
- Data to demonstrate statewide trends on key indicators such as rates of homelessness and suicide that show how well the act's programs help those living with mental illness to function independently and successfully.
- A rotating showcase of model programs in each of the component areas to clearly demonstrate examples of what works.
- All county MHSA plans and reports submitted to the state, including:
 - ✓ MHSA annual revenue and expenditure reports.
 - ✓ Three-year program and expenditure plans and annual updates.
 - ✓ Other relevant mental health reports, such county cultural competence plans that describe how a county intends to reduce mental health service disparities identified in racial, ethnic, cultural, linguistic and other unserved and underserved populations.

Recommendation 4: To promote meaningful accountability of the MHSA, the state needs access to reliable, timely information that allows it to monitor effective progress toward the act's goals. The Mental Health Services Oversight and Accountability Commission and Department of Health Care Services should:

- Immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system capable of incorporating data for all MHSA components, as well as other state behavioral and mental health programs.
 - ✓ This plan should address how the development of such a data collection system would be funded and should use a portion of the MHSA state administrative funds to support the effort.
- Regularly report to the Legislature on the progress made in developing this data system and identify challenges that arise.

Appendix C: Examples of Statutory Roles and Responsibilities Assigned to Mental Health Agencies

State law – California’s Welfare and Institutions Code – prescribes various roles and responsibilities for state and local agencies to implement the Mental Health Services Act. Examples of some of these roles and responsibilities are included below.

Code Section	Description	DHCS	MHSOAC	MHPC	Other	County	CBHDA
5655	DHCS shall, upon request and with available staff, provide consultation services to the local mental health directors, local governing bodies and local mental health advisory boards. If the director of DHCS considers any county to be failing, in a substantial manner, to comply with any provision of this code or any regulation, the director shall order the county to appear at a hearing, before the director or the director’s designee, to show cause why the department should not take action. If the director finds there has been a failure, the DHCS may withhold part or all of state mental health funds for the county, require the county to enter into negotiations for the purpose of ensuring county compliance with those laws and regulations and bring court action as appropriate to compel compliance.	✓					
5722	The MHPC shall have the powers and authority necessary to, among other duties, review, assess and make recommendations regarding all components of California’s mental health system, review program performance in delivering mental health services by annually reviewing performance outcome data, identify successful programs for recommendation and for consideration of replication in other areas, advise the DHCS if a county’s performance is failing, advise the Legislature, DHCS and county boards on mental health issues and the policies and priorities the state should be pursuing in developing its mental health system.			✓			
5845 (a)	MHSOAC established to oversee: Part 3: the Adult and Older Adult Mental Health System of Care, Part 3.1: Human Resources, Education and Training Programs, Part 3.2: Innovative Programs, Part 3.6: Prevention and Early Intervention Programs, Part 4: Children’s Mental Health Services Act		✓				
5845 (d) (6)	In carrying out its duties, the MHSOAC may, among other things, obtain data and information from DHCS, OSHPD or other state or local entities that receive MHSA funds for the commission to utilize in its oversight, review, training and technical assistance, accountability and evaluation capacity regarding projects and programs supported with the MHSA funds	✓	✓		✓		✓
5845 (d) (9)	Advise the Governor or Legislature regarding actions the state may take to improve care and services for people with mental illness.		✓				
5845 (d) (10)	If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the DHCS.	✓	✓				
5845 (d) (11)	Assist in providing technical assistance to accomplish the purposes of Part 3, Part 4 in collaboration with the DHCS and in consultation with the CBHDA	✓	✓				✓

Code Section	Description	DHCS	MHSOAC	MHPC	Other	County	CBHDA
5845 (d) (12)	The MHSOAC may work in collaboration with DHCS and the Mental Health Planning Council, and in consultation with the CBHDA, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including but not limited to parts listed in 5845(a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.	✓	✓	✓	✓		✓
5897 (c)	The DHCS shall implement the provisions of Part 3, Part 3.2, Part 3.6 and Part 4 through the annual county mental health services performance contract.	✓				✓	
5897 (d)	The DHCS shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding.	✓				✓	
5897 (e)	When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its website any plans of correction requested and the related findings.	✓				✓	
5898	The DHCS, in consultation with the MHSOAC, shall develop regulations, as necessary, for the DHCS, the MHSOAC, or designated state and local agencies to implement this act.	✓	✓		✓	✓	
5899 (b)	The DHCS, in consultation with the MHSOAC and CBHDA shall revise the instructions for the Annual Mental Health Services Act Revenue and Expenditure Report by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.	✓	✓			✓	

Notes:

DHCS: California Department of Health Care Services

MHSOAC: Mental Health Services Oversight and Accountability Commission

MHPC: California Mental Health Planning Council

Other: A state agency, other than DHCS, MHSOAC, MHPC

CBHDA: County Behavioral Health Directors Association, formerly, County Mental Health Directors Association

Appendix D: County Submission Status of MHSA Annual Revenue and Expenditure Reports (as of August 26, 2016)

County	Fiscal Year	
	13-14	14-15
Alameda		
Alpine		
Amador		
Berkeley City	✓	✓
Butte	✓	✓
Calaveras	✓	✓
Colusa	✓	✓
Contra Costa	✓	✓
Del Norte	✓	✓
El Dorado	✓	✓
Fresno	✓	✓
Glenn	✓	✓
Humboldt	✓	
Imperial	✓	✓
Inyo	✓	✓
Kern	✓	
Kings	✓	✓
Lake		
Lassen	✓	
Los Angeles		
Madera		
Marin		
Mariposa		
Mendocino	✓	
Merced	✓	
Modoc	✓	✓
Mono	✓	✓
Monterey		
Napa		
Nevada	✓	

County	Fiscal Year	
	13-14	14-15
Orange	✓	✓
Placer		
Plumas		
Riverside	✓	
Sacramento		
San Benito	✓	
San Bernardino	✓	✓
San Diego	✓	✓
San Francisco	✓	✓
San Joaquin		
San Luis Obispo	✓	✓
San Mateo		
Santa Barbara		
Santa Clara		
Santa Cruz	✓	
Shasta	✓	
Sierra		
Siskiyou		
Solano	✓	✓
Sonoma		
Stanislaus	✓	✓
Sutter-Yuba		
Tehama	✓	✓
Tri-City	✓	✓
Trinity	✓	
Tulare	✓	✓
Tuolumne	✓	✓
Ventura	✓	✓
Yolo		

Source: Kendra Penner, Legislative Coordinator, Department of Health Care Services. August 30, 2016. Personal communication with Commission staff.

Total FY 13-14	37
Total FY 14-15	26

NOTES

- 1 Department of Health Care Services (DHCS). January 2016. Mental Health Services Act Expenditure Report: Fiscal year 2016-2017. Also, Mental Health Services Oversight and Accountability Commission (MHSOAC). "Proposition 63 History." Accessed August 5, 2016 at <http://mhsaac.ca.gov/history>
- 2 Secretary of State Kevin Shelley. November 2, 2004. Official Voter Information Guide. Page 34.
- 3 Welfare & Institutions Code, Sections 5845(d)(11), 5845(d)(12), 5898, 5899(a-b).
- 4 Welfare & Institutions Code, Section 5655.
- 5 DHCS. See Endnote 1.
- 6 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. July 12, 2016. Personal communication with Commission staff.
- 7 Toby Ewing, Executive Director, MHSOAC. May 26, 2016. Testimony to the Commission. Accessed September 8, 2016 at http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=3752.
- 8 Department of Health Care Services. September 23, 2015. MHSUDS Information Notice: 15-042. Subject: Annual review protocol for consolidated Specialty mental health services and other funded services for fiscal year 2015-16.
- 9 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. May 26, 2016. Testimony to the Commission.
- 10 Welfare & Institutions Code, Section 5899.
- 11 Kendra Penner, Legislative Coordinator, Department of Health Care Services. August 30, 2016. Personal communication with Commission staff.
- 12 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. September 23, 2014 and May 26, 2016. Written testimony to the Commission.
- 13 Welfare & Institutions Code, Section 5655. Also, Karen Baylor. See Endnotes 6 and 12.
- 14 Brian Sala, Deputy Director, and Filomena Yeroshek, Chief Counsel, MHSOAC. July 8, 2016. Personal communication with Commission staff.
- 15 DHCS. See Endnote 1.
- 16 Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California. May 26, 2016. Written testimony to the Commission.
- 17 Toby Ewing. See Endnote 7, hearing video at 1:50:04 to 1:51:37.
- 18 Welfare & Institutions Code, Section 5772(b) and (c).
- 19 Welfare & Institutions Code, Sections 5820 and 5821.
- 20 DHCS. See Endnote 1.
- 21 Welfare & Institutions Code, Sections 5847 and 5848.
- 22 AB 1618 (Committee on Budget). Chapter 43, Statutes of 2016. Also, Welfare & Institutions Code, Section 5848(e).
- 23 Brian Sala. See Endnote 14.
- 24 Josephine Black, Chairperson, and Jane Adcock, Executive Officer, California Mental Health Planning Council. May 26, 2016. Written testimony to the Commission.
- 25 Darrell Steinberg, former Senate Pro Tem and Founder, Steinberg Institute. May 26, 2016. Testimony to the Commission.
- 26 MHSOAC. See Endnote 1.
- 27 MHSOAC. "County Submitted Reports." Accessed August 5, 2016 at <http://mhsaac.ca.gov/county-submitted-reports>. Also, "Ensuring Fiscal Accountability" at <http://mhsaac.ca.gov/ensuring-fiscal-accountability>. Also, "Measuring Outcomes" at <http://mhsaac.ca.gov/measuring-outcomes>.
- 28 DHCS. See Endnote 1.
- 29 Matthew Gallagher, Program Director, California Youth Empowerment Network. May 5, 2016. Public comment to the Commission.
- 30 Sally Zinman, Executive Director, California Association of Mental Health Peer Run Organizations. May 25, 2016. Written testimony to the Commission.
- 31 Toby Ewing. See Endnote 7.
- 32 Brian Sala, Deputy Director, MHSOAC. July 29, 2016. Personal communication with Commission staff.
- 33 AB 1618. See Endnote 22. Also, Welfare & Institutions Code, Section 5899.
- 34 Kendra Penner. See Endnote 11.
- 35 Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California. May 2016. Testimony to the Commission.
- 36 DHCS. See Endnote 1.
- 37 Kevin Shelley. See Endnote 2. Pages 107-108.
- 38 Welfare & Institutions Code, Section 5892(d). Also, DHCS. See Endnote 1.
- 39 Toby Ewing. See Endnote 7.
- 40 Financial Oversight Committee, MHSOAC. Minutes. March 27, 2015. Accessed July 18, 2016 at http://archive.mhsaac.ca.gov/Meetings/docs/Meetings/2015/March/FOC/FOC_032715_Agenda.pdf.
- 41 The WayBack Machine Internet Archive. Captured January 21, 2012,

http://www.dmh.ca.gov/Prop_63/MHSA/State_Interagency_Partners.asp.

42 Darrell Steinberg. May 5, 2016. Steinberg Institute and County Behavioral Health Directors Association press event. Sacramento, California.

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44 Toby Ewing. See Endnote 7.

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48 Dan Hon. November 30, 2015. Code for America Blog Archive. "A New Approach to Procuring Government Technology in California." Accessed July 28, 2016 at <https://www.codeforamerica.org/blog/2015/11/30/a-new-approach-to-procuring-government-technology-in-california/>. Also, V. David Zvenyach and Andre Francisco, 18F. March 22, 2016. "From 1,500 pages to 10: Helping California buy a new Child Welfare System." Accessed July 28, 2016 at <https://18f.gsa.gov/2016/03/22/helping-california-buy-a-new-child-welfare-system/>.

49 Debbie Innes-Gomberg, District Chief, Los Angeles County MHSA Implementation and Outcomes Division. May 26, 2016. Testimony to the Commission.

50 Adrienne Shilton, Director of Intergovernmental Affairs, County Behavioral Health Directors Association of California. July 7, 2016. Personal communication to Commission staff.

51 Debbie Innes-Gomberg, District

Chief, and Kara Taguchi, Phys.D., Los Angeles County MHSA Implementation and Outcomes Division. June 16, 2016. Personal communication with Commission Staff. Long Beach, California. Also, Debbie Innes-Gomberg, See Endnote 49.

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54 Adrienne Shilton. See Endnote 50.

55 Wayne Clark, Executive Director, California Mental Health Services Authority. May 20, 2016. Written testimony to the Commission.

56 Josephine Black, Chairperson, Mental Health Planning Council (MHPC). June 8, 2016. "Letter to Honorable Kevin de Leon, President Pro Tempore, California State Senate RE: No Place Like Home Legislation – Oppose unless amended." Also, Josephine Black, Chairperson, MHPC. June 24, 2016. "Letter to Assembly Member Kevin McCarty RE: AB 2017 College Mental Health Services Program – Oppose."

57 AB 847 (Mullin and Ridley-Thomas), AB 1618 (Committee on Budget), AB 2017 (McCarty), SB 614 (Leno), SB 852 (Budget Trailer Bill).

58 Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition. May 26, 2016, Testimony to the Commission.

59 California Juvenile Justice Data Working Group. January 2016. "Rebuilding California's Juvenile Justice Data System: Recommendations to

Improve Data Collection, Performance Measures and Outcomes for California Youth."

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61 Welfare & Institutions Code, Section 5848(a).

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63 Racial and Ethnic Mental Health Disparities Coalition (REMHDCO). July 20, 2016. Survey on Proposition 63/Mental Health Services (MHSA) community planning process.

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70 Toby Ewing. See Endnote 7. Also, California Enacted Budget. MHSOAC. Accessed July 21, 2016 at <http://www.ebudget.ca.gov/2016-17/pdf/Enacted/GovernorsBudget/4000/4560.pdf>.

Little Hoover Commission Members

CHAIRMAN PEDRO NAVA (*D-Santa Barbara*) Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Advisor to telecommunications industry on environmental and regulatory issues and to nonprofit organizations. Former state Assemblymember. Former civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

VICE CHAIRMAN JACK FLANIGAN (*R-Granite Bay*) Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2012. A member of the Flanigan Law Firm. Co-founded California Strategies, a public affairs consulting firm, in 1997.

SCOTT BARNETT (*R-San Diego*) Appointed to the Commission by former Speaker of the Assembly Toni Atkins in February 2016. Founder of Scott Barnett LLC, a public advocacy company, whose clients include local nonprofits, public charter schools, organized labor and local businesses. Former member of Del Mar City Council and San Diego Unified School District Board of Trustees.

DAVID BEIER (*D-San Francisco*) Appointed to the Commission by Governor Edmund G. Brown Jr. in June 2014. Managing director of Bay City Capital. Former senior officer of Genetech and Amgen. Former counsel to the U.S. House of Representatives Committee on the Judiciary. Serves on the board of directors for the Constitution Project.

SENATOR ANTHONY CANNELLA (*R-Ceres*) Appointed to the Commission by the Senate Rules Committee in January 2014. Elected in November 2010 and re-elected in 2014 to the 12th Senate District. Represents Merced and San Benito counties and a portion of Fresno, Madera, Monterey and Stanislaus counties.

ASSEMBLYMEMBER CHAD MAYES (*R-Yucca Valley*) Appointed to the Commission by former Speaker of the Assembly Toni Atkins in September 2015. Elected in November 2014 to the 42nd Assembly District. Represents Beaumont, Hemet, La Quinta, Palm Desert, Palm Springs, San Jacinto, Twentynine Palms, Yucaipa, Yucca Valley and surrounding areas.

DON PERATA (*D-Orinda*) Appointed to the Commission in February 2014 and reappointed in January 2015 by the Senate Rules Committee. Political consultant. Former president pro tempore of the state Senate, from 2004 to 2008. Former Assemblymember, Alameda County supervisor and high school teacher.

ASSEMBLYMEMBER SEBASTIAN RIDLEY-THOMAS (*D-Los Angeles*) Appointed to the Commission by former Speaker of the Assembly Toni Atkins in January 2015. Elected in December 2013 to represent the 54th Assembly District. Represents Century City, Culver City, Westwood, Mar Vista, Palms, Baldwin Hills, Windsor Hills, Ladera Heights, View Park, Crenshaw, Leimert Park, Mid City, and West Los Angeles.

SENATOR RICHARD ROTH (*D-Riverside*) Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to the 31st Senate District. Represents Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris and Riverside.

JONATHAN SHAPIRO (*D-Beverly Hills*) Appointed to the Commission in April 2010 and reappointed in January 2014 by the Senate Rules Committee. Writer and producer for FX, HBO and Warner Brothers. Of counsel to Kirkland & Ellis. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

JANNA SIDLEY (*D-Los Angeles*) Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. General counsel at the Port of Los Angeles since 2013. Former deputy city attorney at the Los Angeles City Attorney's Office from 2003 to 2013.

HELEN TORRES (*NPP-San Bernardino*) Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. Executive director of Hispanas Organized for Political Equality (HOPE), a women's leadership and advocacy organization.

SEAN VARNER (*R-Riverside*) Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. Managing partner at Varner & Brandt LLP where he practices as a transactional attorney focusing on mergers and acquisitions, finance, real estate and general counsel work.

“Democracy itself is a process of change, and satisfaction and complacency are enemies of good government.”

*Governor Edmund G. “Pat” Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California*

1 TAB SECTION

DATE OF MEETING 10/20/2016

MATERIAL
PREPARED BY: Wiseman

DATE MATERIAL
PREPARED 9/19/2016

AGENDA ITEM:	Trauma Informed Care for Children and Youth
ENCLOSURES:	Excerpt from Stanford Youth Solutions website

BACKGROUND/DESCRIPTION:

This presentation will provide Council members with information regarding trauma informed care for children and youth as well as protocols for use of psychotropic medication from a provider here in Sacramento County.

Dr. Laura Heintz is the Chief Executive Officer of Stanford Youth Solutions, formerly Stanford Home for Children, in Sacramento, CA. She has been in the health and human services field for over 25 years. Before becoming CEO at Stanford Youth Solutions, she served as an in-home behavioral support counselor and social worker. Dr. Heintz is a national speaker through the Annie E. Casey Foundation where she focuses her efforts on redesigning the Child Welfare and Juvenile Justice System. She serves as a member of the statewide Prevent Child Abuse Advisory Committee. Dr. Heintz holds a Doctorate in Psychology and was recently featured in Sacramento Magazine's "The Faces of Downtown 2016".

Stanford Youth Solutions was originally founded in 1900 through the donation of the Stanford Mansion, which was operated as an orphanage by the Catholic Diocese. Their current mission is to "provide intensive, individualized programs that empower young people and families to solve serious challenges that threaten their ability to stay together."

Stanford Youth Solutions website can be found at <http://www.youthsolutions.org>

Stanford Youth Solutions

Excerpt from website

Our Mission, Vision, and Values

October 21, 2010

Stanford Youth Solutions empowers youth and families to solve serious challenges that threaten their ability to stay together. We provide intensive, individualized programs that are proven effective for young people and families in difficult circumstances. They become stable and capable through our research-based, individualized approach.

We are determined to give each and every child a chance at a healthy, productive, and self-sufficient life. It is our unwavering commitment to the sustainable success of our young people and their families.

Mission

Inspiring sustainable change for young people and their families and empowering them to solve serious challenges together.

Vision

We envision a community where every young person has strong and permanent connections to family and the opportunity to develop as a healthy and productive young adult.

Values

Accountability, Empowerment, Excellence, Innovation, Integrity, Partnership

Our Promise

October 20, 2010

We are determined to do whatever it takes to provide young people with a chance at a healthy, productive and self-sufficient life. It is our unwavering commitment, both in theory and practice, to the sustainable success of our young clients and their families that separates us from other, similar organizations.

How we work

1. **Data Driven.** We incorporate nationally recognized models and evidence-based interventions within our programs. Programs are based not only on outcome research but also on the experience of the clinician and on the preferences and assumptions of a client and his or her family. By using this data, we increase positive outcomes for youth and families.

2. **Family Centered.** Family-centered practice means that we work with the family as the primary focus of attention, support and intervention, promoting the safety, well-being and permanent connections between family members, including children identified as needing specific care and attention. Caregivers and siblings receive services in accordance with the needs of the family and the wishes of a family-driven team. Unbiased information is shared with families on a continual basis in order to support their need and ability to make decisions with adequate information. True family/professional collaboration is sought, not just coordination, recognizing that the family should always be the constant in a child's life.
3. **Strength-Based.** The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities by focusing on family strengths, not on problems or deficits. These strengths are also leveraged to address challenges and needs identified by the family.
4. **Family Participation, Voice, and Choice.** Families have voice and choice in the development and implementation of their child and family plan. Families are recognized as knowing themselves better than anyone and are encouraged to use their expert knowledge throughout decision and goal-making processes. We provide individualized, culturally-responsive, and relevant services for each family. In addition, we involve families in creating agency policies and programs.
5. **Community-Based.** Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among community and/or neighborhood systems that are directly involved with the family. Planning and services occur in communities where families live. Families are encouraged to engage in family to family support and networking. Institutional settings are seen as temporary resources, not long-term "placements."
6. **Outcome Driven Services.** Stanford Youth Solutions examines and evaluates program implementation and family centered outcomes achieved through the use of scientific research and analysis. We adopt new methods (and abandon others) in accordance with research findings and family centered practice principles and approaches.
7. **Individualized Services.** Planning and services are individualized. The plans -including the strengths, the needs, the options, the strategies, and the plan- are developed by unique teams comprised of children and families.
8. **Child and Family Teams Driven.** Planning and services are team-driven. Each family's plan is developed by a unique child and family team with oversight and facilitation from a trained professional.
9. **Needs Driven Services.** Services provided are inspired by the prioritized needs of the families served, across all life-domains, not the categories determined by others. Planning and services are comprehensive.
10. **Unconditional Care and Regard.** Planning, support and intervention occurs in an environment of unconditional acceptance. As individual and family needs change, the plans, strategies, and services change. Length of service is based on clinical need as determined by treatment team members in collaboration with the child/youth/family and ACCESS Team authorization.
11. **Culturally Competent.** Planning and services are grounded in the family's culture, values and norms. Staff members strive to become educated and sensitive to the unique culture of each family.



Adverse Childhood Experiences and the Lifelong Consequences of Trauma

Many people can identify a person in their lives who struggles with a chronic illness like heart disease, diabetes, or hypertension. Most people also know someone who struggles with mental illness, substance abuse, or relationships in general. Traditionally, the health care system would point to high-risk behaviors such as poor diet, drug use, or a sedentary lifestyle as the primary causal factors. Questions for patients have focused on “What’s wrong with you?” rather than “What happened to you?” A 1998 study from the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente is leading to a paradigm shift in the medical community’s approach to disease. This study of more than 17,000 middle-class Americans documented quite clearly that adverse childhood experiences (ACEs) can contribute significantly to negative adult physical and mental health outcomes and affect more than 60% of adults.^{1,2} This continues to be reaffirmed with more recent studies.



Adverse childhood experiences include

- *Emotional abuse*
- *Physical abuse*
- *Sexual abuse*
- *Emotional neglect*
- *Physical neglect*
- *Mother treated violently*
- *Household substance abuse*
- *Household mental illness*
- *Parental separation or divorce*
- *Incarcerated household member*

Along with the original 1998 ACE Study, there are known predictive factors that make sense to include in the list of adverse experiences. These can be single, acute events or sustained over time. Examples include death of a parent and the detrimental effect of community violence and poverty, among others.³ Adverse childhood experiences occur regularly with children aged 0 to 18 years across all races, economic classes, and geographic regions; however, there is a much higher prevalence of ACEs for those living in poverty.

While some stress in life is normal—and even necessary for development—the type of stress that results when a child experiences ACEs may become toxic when there is “strong, frequent, or prolonged activation of the body’s stress response systems **in the absence of the buffering protection of a supportive, adult relationship.**”^{4,5} The biological response to this toxic stress can be incredibly destructive and last a lifetime. Researchers have found many of the most common adult life-threatening health conditions, including obesity, heart disease, alcoholism, and drug use, are directly related to childhood adversity. A child who has experienced ACEs is more likely to have learning and behavioral issues and is at higher risk for early initiation of sexual activity and adolescent pregnancy. These effects can be magnified through generations if the traumatic experiences are not addressed. The financial cost to individuals and society is enormous.⁶

Never before in the history of medicine have we had better insight into the factors that determine the health of an individual from infancy to adulthood, which is part of the **life course perspective**—a way of looking at life not as disconnected stages but as integrated across time.

What happens in different stages of life is influenced by the events and experiences that precede it and can influence health over the life span. An expanding body of convergent knowledge generated from distinct disciplines (neuroscience, behavioral science, sociology, medicine) provides child health care professionals the opportunity to reevaluate what care is needed to maximize the effect on a child’s lifelong health. Importantly, an extensive body of research now exists demonstrating the effect of traumatic stress on brain development. Healthy brain development can be disrupted or impaired by prolonged, pathologic stress response with significant and lifelong implications for learning, behavior, health, and adult functioning.⁴

WHAT IS THE ROLE OF STRESS?



Stress in itself need not result in injury and is, by its nature, a subjective experience. Stress in a supportive environment may not be toxic. The perception of stress varies from child to child; serious threats may not disturb one child, while minor ones may be traumatic to another. This variability is multifactorial depending on a child’s previous trauma, social-emotional support, and genetic predisposition.

Just as the stress of ambulation helps promote bone and muscle growth, a child needs to experience some emotional stress to develop healthy coping mechanisms and problem-solving skills. Experts categorize stress as *positive*, helping to guide growth; *tolerable*, which, while not helpful, will cause no permanent damage; or *toxic*, which is sufficient to overcome the child’s undeveloped coping mechanisms and lead to long-term impairment and illness.⁵

Toxic stress response can occur when a child experiences strong, frequent, or prolonged adversity, such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, or the accumulated burdens of family economic hardship, in the absence of adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk of stress-related disease and cognitive impairment well into the adult years.

THE BIOLOGY OF TRAUMA

The National Child Traumatic Stress Network (NCTSN) definition of *traumatic stress* encompasses the physical and emotional responses of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (eg, parent, sibling). It is this out-of-control physiological arousal that is the hallmark of stress that becomes traumatic and can incite what is initially an adaptive response to the stressor that ultimately becomes maladaptive and destructive. While a single event like a natural disaster or an assault by a stranger may constitute toxic stress, the effects multiply when the trauma continues, whether by repetition of similar stresses (eg, an environment of domestic violence or parental drug abuse) or accumulation of disparate ones (eg, parental illness and a hurricane hits town). In other words, there is a dose-response relationship. The effect may be particularly severe when trauma involves the child's primary caregiving system. Termed *complex trauma* by the NCTSN, this reaction develops over time, as subsequent events reinforce the lessons learned previously.⁷

The effect of toxic stress resulting from trauma may not be immediately visible or appear as one would expect. In addition, some traumatic sources of toxic stress may not be readily apparent to the clinician. Psychological maltreatment can be traumatic and stressful.⁸ Neglect can also be traumatic. Neglect is almost always chronic, as basic needs such as food, shelter, or emotional security are continually not being met. Neglect is often seen in conjunction with abuse and may be exceptionally severe; 71% of child maltreatment fatalities are due to neglect exclusively or in combination with another maltreatment type.⁹

For most children who have experienced trauma and toxic stress, the experiences began at an early age. As a result, the events may be remote and documented history is often buried among old records or nonexistent. Prenatal exposures that influenced brain development may not be detectable in obstetric records. Pediatricians should understand that presentations of attention deficits, emotional dysregulation, and oppositional behaviors may have their roots in early abuse or neglect or other sources of toxic stress. Recognition of the power of early adversity to affect the child's perceptions of and responses to new stimuli may aid the pediatrician or other clinician in appropriately understanding the causes of a child's symptoms.

The past few years have brought a dramatic improvement in our understanding of how a healthy brain develops and the effect, positive or negative, that a child's environment has on that process. Several systems—social/behavioral, neuroendocrine, and even genetic—are all influenced by early experiences and interact with each other as a child grows and develops. The ability of an individual to successfully overcome negative experiences from trauma depends on many factors related to the complex interaction between these systems. Several key observations have emerged from recent research.

- *The brain is not structurally complete at birth.*
 - Myelination, proliferation of synaptic connections, and development of glial and circulatory support systems all continue long after a child has entered the world. Nature gives children a chance to adapt to the specific needs presented by the environment into which they have been born.

Among other things, optimal development of the neuroendocrine system is dependent on adequate nutrition and absence of toxins like lead, mercury, alcohol, other drugs, and toxic stress.

- *Structural development is guided by environmental cues.*
 - An infant's brain adapts to what it sees, hears, and feels. Researchers have demonstrated critical periods for effective development of many brain systems.

Proper structural growth depends on a nurturing, loving, and stimulating environment, one that prepares the child for future circumstances.

- *Effective stimulation requires interaction with other people.*
 - Children can't be expected to provide their own high-quality stimulation. They learn from every person encountered—especially primary caregivers.

Other people must be present, attentive enough, and consistent or predictable enough to teach the lessons the developing brain needs. Stimulation from television, smartphones, or tablets does not replace interaction with people.

- **Gene expression determines neuroendocrine structure and is strongly influenced by experience.**

- Genetic research has identified a variety of alleles that appear to protect against, or predispose to, long-term sequelae of traumatic stress by varying the sensitivity of stress hormone receptors in the limbic system.^{10,11,12} An increasing body of evidence points to the ability of early life experience to trigger epigenetic modifications, effectively altering brain structure by changing gene transcription.^{13,14}

One way, then, that early adversity can affect long-term change is by altering the way an individual's genetic blueprint is read, thus influencing the stress response.

- **The body's systems are mutually interactive.**

- Social interactions (or the lack thereof) may affect neuroendocrine development, which can alter observed behaviors (Figure 1). Behavior, in turn, produces social feedback, which stimulates a neuroendocrine response (a physiological response) and, if severe, may cause modifications in brain structures (an anatomic response). Another word for this complex system of interactions is *learning*. When the body learns under conditions of extreme stress, epigenetic modifications in gene transcription can be produced and cause structural changes in the developing brain.^{12,15} This process can operate both ways. The epigenetic modifications to gene transcription ultimately determine the brain's structure, which governs behavior. The behavior can result in interactions that reinforce or reactivate the stress response, causing additional negative modifications to the brain architecture. This interactive cascade of responses among social/behavioral, neuroendocrine, and genetic/epigenetic systems has recently been dubbed the ecobiodevelopmental model.⁴

The more emotionally charged a learning situation is, the more likely it is to result in long-term modifications.

EFFECT OF TRAUMA ON PARENTING ABILITY



Adults who have experienced ACEs in their early years can exhibit reduced parenting capacity or maladaptive responses to their children. The physiological changes that have occurred to the adult's stress response system as a result of earlier trauma can result in diminished capacity to respond to additional stressors in a healthy way. Adverse childhood experiences increase the chance of social risk factors, mental health issues, substance abuse, intimate partner violence, and adult adoption of risky adult behaviors. All of these can affect parenting in a negative way and perpetuate a continuing exposure to ACEs across generations by transmission of epigenetic changes to the genome.

RESILIENCE AND OTHER REASONS FOR OPTIMISM



Adverse experiences and other trauma in childhood, however, do not dictate the future of the child. Children survive and even thrive despite the trauma in their lives. For these children, adverse experiences are counterbalanced with protective factors. Adverse events and protective factors experienced together have the potential to foster resilience. Our knowledge about what constitutes resilience in children is evolving, but we know that several factors are positively related to such protection, including cognitive capacity, healthy attachment relationships (especially with parents and caregivers), the motivation and ability to learn and engage with the environment, the ability to regulate emotions and behavior, and supportive environmental systems,

Figure 1.

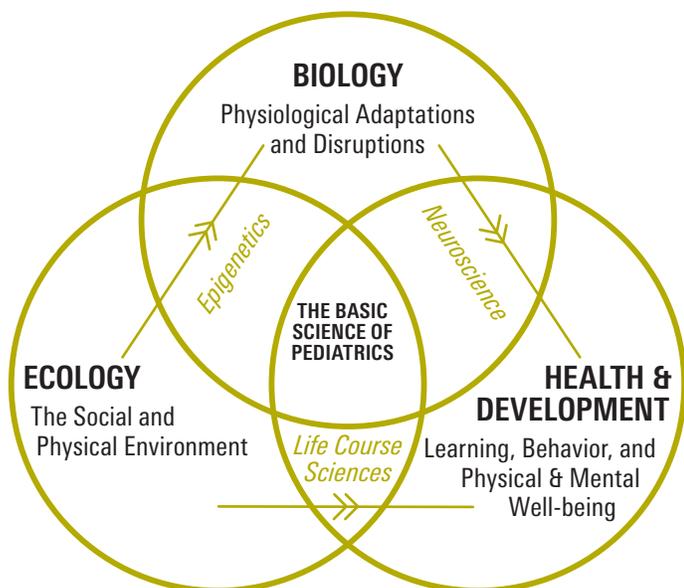


Figure 1. The basic science of pediatrics. An emerging, multidisciplinary science of development supports an ecobiodevelopmental framework for understanding the evolution of human health and disease across the life span. In recent decades, epidemiology, developmental psychology, and longitudinal studies of early childhood interventions have demonstrated significant associations between the ecology of childhood and a wide range of developmental outcomes and life course trajectories. Concurrently, advances in the biological sciences, particularly in developmental neuroscience and epigenetics, have made parallel progress in beginning to elucidate the biological mechanisms underlying these important associations. The convergence of these diverse disciplines defines a promising new basic science of pediatrics.

including education, cultural beliefs, and faith-based communities.¹⁶ The **protective factors framework** developed by Strengthening Families¹⁶ as well as the **Essentials for Childhood** program from the CDC¹⁷ provide more detail.

There are additional reasons for optimism. There now exist several evidence-based, effective clinical treatments to call on in intervening with children who have experienced trauma and adversity, including Trauma-Focused Cognitive-Behavioral Therapy¹⁸ and Parent-Child Interactive Therapy.¹⁹ Each of these programs includes attention to parenting ability and works on establishing behaviors that promote resilience in the child and parent. Proactive initiatives like home visitation programs for high-risk families, though not widely disseminated, have incredible promise for the prevention or mitigation of parent- and environment-mediated ACEs specifically because they are focused on critical periods in human development—prenatal through the first 2 to 3 years of life.²⁰

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The recommendations in this toolkit do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.