

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEETING MINUTES
June 16 and 17, 2010
Hilton, Oakland Airport
One Hegenberger Road
Oakland, CA 94621

CMHPC Members Present:

Gail Nickerson, Chair
Renee Becker
Lin Benjamin
Sophie Cabrera
Doreen Cease
Adrienne Cedro-Hament
Nadine Ford
George Fry, Jr.
Jorin Bukosky
Michael Cunningham
Marissa Lee
Joseph Mortz
Jonathan Nibbio
Karen Hart
Walter Shwe

Susan Mandel, PhD
Barbara Mitchell
Jennie Montoya
Kathleen O'Meara
Mark Refowitz
John Ryan
Daphne Shaw
Linne Stout
Stephanie Thal, MFT
Ed Walker, LCSW
Monica Wilson, PhD
Susan Wilson
Carmen Lee
Patrick Henning
Grant Jordan
Karen Allen

Staff Present:

Ann Arneill-Py, PhD, Executive Officer
Karen Hudson
Brian Keefer
Andi Murphy
Narkesia Swangian

Tracy Thompson
Michael Gardner
Lisa Williams

Wednesday, June 16, 2010

1. Welcome and Introductions

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

2. Implementation of Mental Health Services Act Housing Program

Linda Aaron-Court of the Department of Mental Health and Kathy Weremiuk of CalHFA presented the program. Some highlights:

- The MHSA Housing Program is a unique collaboration among government agencies at the local and state level.
- The MHSA Housing Program provides the funding for the capital costs to build buildings and operating subsidies to develop permits for supportive housing for persons with mental illness who are homeless or at risk of homeless and who meet the MHSA Housing Program Target Criteria.
- The county mental health programs choose the projects that they want to sponsor that serve clients with the greatest need.
- The counties have a commitment to provide services under the program.
- The three legs of the program are: A: There is capital to interest developers' participation. B: There is a commitment for services. C: There are operating subsidies available.
- In May of 2006 \$400 million was made available.
- Counties assign their monies to CalHFA.
- As of April 45 counties have assigned approximately \$390 million and seven counties have not yet assigned their funds.
- A key objective of the program is that the housing be retained by the clients to support recovery and resiliency.
- Defining housing as a service was very important in the development of the program.
- Children were included in the target population and can be the qualifying tenant.
- A consumer in a situation with no tenant rights (temporary living, couch surfing etc.) qualifies under the program.
- The definition does not stipulate that a client must be living on the street (jail and transitional residential settings discharges qualify) in order to qualify.
- The two models of housing are, 1. A shared housing model where each bedroom is occupied by a qualified tenant and facilities are shared and 2. Rental housing.
- Rental housing is property that is five or more units.

- For rental housing the program was intended to work with the existing funding sources (mainly HCDs, supportive housing programs, the Tax Credit Allocation Program and various county programs).
- To date 93 applications have been received from 28 counties.
- Currently \$219 million has either been committed, closed or the MHSA loans closed or applications going forward.
- The program will create 4,522 units of new, affordable housing.
- A total of 207 units have been designated for seniors only. To date 80 units are designated for TAY.
- The program has been instrumental in establishing best practices for serving TAY and seniors.
- Currently 89 MHSA units are occupied in 9 projects that created 327 units.
- Projects have moved forward in spite of the financial upheavals experienced globally.
- Tax exempt bonding financing is not operational.
- California received \$350 million of ARRA funding.
- The California state budget situation has dampened the counties' confidence in the availability of service funds.
- CIMH technical staff is being encouraged to go on the road and help initiate and close projects throughout the state.
- Semi-annual legislative reports on the DMH website are available and more information is on CalFHA's website as well.

Questions/Answers/Comments with Ms. Aaron-Court and Ms. Weremiuk

Mark Refowitz: What assistance has been offered to small counties? Currently there's a cap on CalFHA monies that counties assign. What is the average number of years of subsidy that buys and is that a problem when you're trying to put financial applications together?

Answer: In response to the second question stated: We don't fund a project that requires rental subsidies unless we can get it out to 15 years. The dollar amount has been raised by four percent every year and this has helped in the more expensive counties. Ms. Aaron-Court responded to the first question by stating: The Department and Cal HFA have worked with the small counties from the beginning. It is challenging for the smaller

counties to put together application because of infrastructure, partnering issues and they may not have anybody locally that wants to work with them in terms of being the developer. We continue to offer technical assistance. This is an ongoing project.

Barbara Mitchell: Can you talk about the issues on the maximum capitalized rent subsidies?

Answer: Ms. Aaron-Court said that her understanding is the Department at this time does not have the authority to unilaterally change the program and the intention was to have the bulk of the funds go toward capital. Ms. Weremiuk stated that it is on a case-by-case basis.

Renee Becker: How do you assure that when there's limited beds and they've got adults, transition age youth, and older adults that those are really being allotted for TAY when you only have five beds?

Answer: Ms. Weremiuk answered that there are two ways that they know, one is that the county and the developer do a Service Plan and an MOU and they tell us what their tenant selection will be and their screening will be. They sign a regulatory agreement that they will follow through on that Service Plan. And then we monitor occupancy and what's happened in the project and the Department will have people going out. We look at it from three different ways, the Department, ourselves and the county.

Joseph Mortz: I would like to see if you could extrapolate the numbers of people served over the life of 20 years for this investment what the unit costs are.

Answer: Ms. Weremiuk responded by stating that the cost per unit if there's full-operating subsidy and full capital subsidy would be about \$216,000 for 20 years. The units are generally restricted for 55 years. Units in California can cost anywhere from 300 to 600,000 to build. The operating subsidy would be there irrespective. The capital costs on housing are high. Ms. Aaron-Court added that she thought that there are studies that have been done and they can try to access them for the Council.

Ed Walker: I took Joe's question as a type of suggestion that in the future, it would be useful if reports or presentations have a segment that addresses the costs in a matrix display which could give ranges and types of situations.

Answer: Joe Mortz concurred with Mr. Walker's comments.

Sheree Kruckenberg: Ms. Kruckenberg with the California Hospital Association stated that their emergency departments are being used as temporary housing for some individuals with mental illness. At some point, money was taken from the Mental Health Services Act to do the housing piece. Do we know how many of those 13 hundred MHSA designated settings are occupied?

Answer: Ms. Weremiuk responded that right now it's about 90 units because housing takes a long time to develop.

Sheree Kruckenberg: So is there a plan for the non-designated units to convert to FSP units?

Answer: Ms. Weremiuk stated: No, the goal with this was to talk developers who have been reticent to develop housing for people who are homeless and mentally ill and to help integrate the homeless, mentally ill into the people who can access the state's affordable housing stock.

Sheree Kruckenberg: Is there a certain percentage that has to be for FSP?

Answer: Ms. Weremiuk responded: They don't have to be FSP, although counties have tended to designate MHSA units for people who are in FSPs or FSP eligible. We require a minimum of five units in a development.

John Sturm: My question pertains to the life skills that are being developed that would allow the consumers to move on with their life. I was also wondering if you were able to take advantage of the foreclosure situation in obtaining housing.

Answer: Ms. Aaron-Court: As Kathy mentioned the projects submit very critical fiscal information and then there's a Supportive Services Plan requirement. It lists the kinds of services that the Department thinks are appropriate including a vast array of different life skills. Ms. Weremiuk: There were two aspects of the foreclosure crisis, maybe three that we could take advantage of. One was that people had projects that were ongoing where costs had escalated and they couldn't get anymore local financing and they turned to this program saying, we would like some MHSA units for the funding. The other was that there's less funding available so more developers have come around. The third is buying foreclosed homes and that's been a little more of a challenge but we're starting to see that happen now.

3. Report from the Department of Mental Health

Mr. Stan Bajorin, Acting Chief Deputy Director, Department of Mental Health

- Revenues are up slightly, about \$590 million but that's only three percent of the state deficit of \$20 billion.
- The Conference Committee is now meeting to sort out the issues and give the Governor a budget as quickly as they can.
- Because the constitutional deadline has passed to submit a budget, the State Controller has issued a letter that tells the Governor and the Legislature that the state is out of cash.
- The Controller will borrow \$20 billion dollars from special funds within the state of California.
- When this money runs out (in about 30 days) he'll have to continue to borrow money from other sources.
- He is projecting that the state will run out of cash in August.

- The Controller is very limited in the bills he can pay when this happens.
- He can pay continuous appropriations such as Mental Health Services Act dollars.
- As of July 1 forward, without a budget, vendors cannot be paid.
- There are certain payments that the Department of Mental Health cannot pay to the counties.
- The state of California cannot pay counties any General Fund money out of Department of Mental Health's budget starting July.
- The EPSDT portion can be paid without a state budget but only for a limited time.
- Department of Mental Health has a fund of about \$2 billion that can reimburse MediCal payments both institutional and non-institutional providers.
- Last year this fund lasted about three weeks.
- The Department of Mental Health and the Department of Health Care Services are working on a possible solution to this, either extending or increasing the loan authority that the Department of Health Care Services has, or working towards a continuous appropriation for federal funds that would allow the state Department of Mental health and the Department of Health Care Services to pay without specific annual legislative action.
- Our EPSDT Program appropriation requests of \$1.2 billion and our Managed Care appropriation request were approved by both houses of the Legislature.
- AB 3632 is in conference and we still do not have resolution.
- Currently the state owes counties about \$450 million since 1998 forward and since the passage of 1A it's about \$133 million.
- The Legislature is looking at restoring \$4.8 million to the Caregiver Resource Program that was vetoed by the Governor last cycle.
- Without a state budget, employees of the Department are being directed not to travel in state.
- The Governor's proposal in January to use Proposition 63 money for the General Fund portion of EPSDT and Managed Care failed.

- The realignment proposal shift of over \$600 million from County Mental Health to County Social Services was not accepted by the Senate or the Assembly, however, the issue of realignment is not dead.
- Enhanced FFP at the higher percentage, the Governors budget assumes a six month extension with provisions, should it pass Congress, for an additional six months.
- We are working very closely with the California Mental Health Directors Association and counties with regards to our new claiming, adjudication, and payment system for claims that the counties submit.
- For the consent judgment that the Department is under, US DOJ consent judgment, all our hospitals in that consent judgment are now fully compliant.
- MHSA funding, projections for the budget year, about \$1.1 billion in revenue compared to about 1.4 in the current year.
- For the budget year we have about 43 counties who have submitted Annual Update Plans and those funds will be released upon July 1.
- The Petris Report is now public information and it's being posted on the Department's website.
- On our waiver for specialty mental health services the Department of Health Care Services informed us that CMS has approved the second year of the waiver until June 30th, 2012.
- The demonstration waiver (the 1115 waiver) was sent to CMS June 4th and the Department of Mental Health has been working very closely with DHCS in a task force to develop a new service model that will probably roll out in the second and third years of the waiver.

Questions/Answers and Discussion with Stan Bajorin

Susan Mandel: Any update on Medi-Medi? And is the Department planning on providing late codes to providers?

Answer: We are still working with the Department of Health Care Services to resolve the two codes for which there is no decision yet on whether you have to bill Medicare first or not. Regarding late codes, if the issue is related only to Medi-Medi the Department will provide delayed reason codes for submission of those claims, however, please be aware that the Department of Mental Health cannot allow a claim, cannot adjudicate a claim if it is over 12 months from the month of service, that claim will be denied.

Steve Leoni: A question about the 1115 waiver. I have heard that certain provisions will go into effect in the second or third year. My understanding is that there will be extra dollars for mental health at that point.

Answer: The proposal is for the second and third year of the waiver to have a new delivery system and until DHCS has additional conversation with CMS.

Stephanie Welch: In the renewed 19B waiver I'm unclear as to whether that waiver or the state plan amendment is the appropriate place to insert the definition for peer support as a billable expense under the rehab option. **Answer:** Ms. Sophie Cabrera added that peer support would be appropriate in the state plan but it would have to be defined as a covered service and how it would be operationalized would go into the plan.

Stephanie Welch: So then in terms of process because we don't have a completed state amendment or the contract hasn't been renewed is that we need to ensure that that is in the state plan so that we can then put it in this now renewed waiver. Is that the process?

Answer: Ms. Cabrera: The waiver actually describes what the services are. The Plan tells how we do that in California. It would have to be recognized as a covered service in the waiver and then operationalized in the state plan.

Stephanie Welch: So my question would be is that if it's renewed and it currently doesn't exist in our waiver, does that mean it's not going to be there for the next year of which the 1915 B waiver has been now extended.

Answer: There would need to be an addition or an amendment to it. It's not in there currently. It wouldn't be included. Mr. Bajorin added that there would be a discussion with all stakeholders that wish to participate on the 25th or the 28th of this month to discuss the waiver and the progress on the state plan.

Susan Mandel: I wonder if you knew anything about CalWorks? Do we know what the Governor is going to do? **Answer:** I would have no indication of what the Governor is going to do at this point. The decision really rests with the Legislature at this time. Right now the budget is with the Conference Committee.

Adrienne Cedro-Hament: The concern that I have is that health care reform is beginning to be a rumbling in Los Angeles. The information that I get is that nowhere is mental health being discussed. What is the Department thinking or going to do to assure that mental health is at the table when planning is being done? **Answer:** We're working very closely with the Department of Health Services and advocates in Washington to assure that.

Joe Mortz: I want to echo Ms. Welch's comments about the peers. I have a concern. I have attempted to obtain copies of the Annual Audit for my county and I would like to be able ask them for it. It turns out I have to fill out quite a bit of paperwork and I want an electronic version. I was told I have to pay 10 cents a page. So I'd like to know what the policies are regarding annual audits being public documents and accessibility. Why aren't the audits on the website after they're public and finalized? **Answer:** If there's an audit report that's published it's a public document. There is a priority for full transparency

especially in public documents. The Department is implementing a plan to post our audits online, if you're talking about audits that are performed by the Department of Mental Health. We have not completed that assignment yet but we are working on it. All audits issued by most state departments will be posted on their specific websites because they are public documents.

Marissa Lee: I am the first TAY representative on this Council as of January, 2010. Most TAY policy seems to be set from an administrative provider or parent perspective. In the interest of maintaining an age-balanced perspective on the Council I would like to request that Dr. Mayberg appoint younger adults, someone under age 30, for this position. I would hope that you could bring this request back to Dr. Mayberg and ask that he look at adding either a TAY or, at least someone under age 30, to add some age diversity to the Council. **Answer:** Thank you ma'am. I'll be glad to pass that along to Dr. Mayberg.

Barbara Mitchell: I just wanted to know if the Department has looked at the impact of the elimination of dental, vision and vision services and audio logy services under MediCal? I would like to know if DMH has taken a position on this and is advocating for restoration of these benefits? **Answer:** We are working with the Department of Health Care Services for a policy determination on those issues but really this policy rests with the Department of Health Care Services.

4. Update on Cultural Competence

Ms. Rachel Guerrero presented the following: I am not going to do a formal report on cultural competency today. I came today to announce my retirement at the end of this month. Out of respect for the people I've worked with for over 22 years I'm here to say farewell. I want to thank each and every one of you for your support of moving the cultural competency agenda forward. I will continue to do this work in another form after some rest and some relaxation and some reflection.

Adrienne Cedro-Hament: I just want to underline the fact that we now have a Cultural Competency Competence Committee and that is partly due to Rachel too.

Susan Mandel:: Rachel I want to thank you for always making me a little bit uncomfortable, always making me stretch a little bit farther and it has never ceased to amaze me how for so many years you were a one-woman show carrying the burden of trying to make us all more culturally competent in the state of California. I wish you all the best.

5. Workforce Education and Training: Overview of Implementation

Brian Keefer, Project Manager, Human Resources Project, CA Mental Health Planning Council, Zoey Todd, Department of Mental Health, Adrienne Shilton, Local Workforce Education and Training, California Institute for Mental Health, Christa Thompson,

Mental Health Services Act Coordinator, Calaveras County and Mark Refowitz, Director, Behavioral Health, Orange County made the following presentation:

- The following points apply to findings regarding WET: 1. Perception of workforce being ill-equipped. 2. There is a mal-distribution of the workforce. 3. There are workforce shortages. 4. There is an insufficient diversity in our workforce. 5. There are deficiencies in professional education and a lack of assurance of the competencies and discipline-specific in core knowledge and inadequate faculty development. 6. There are fast-growing diverse populations needing services. 7. Policy-wise there is a blurred mosaic of occupations. 8. Not a lot of occupational analysis has been done.
- Future trends are as follows: 1. An aging workforce. 2. An increasing diversity of populations. 3. An increase with workers with only 2 years of education beyond high school.
- The California Mental Health Planning Council took on this issue in 1999.
- The Council made the conclusion that hard-to-fill positions would not be filled.
- There was a lack of sustainable mechanisms to promote mental health careers both in secondary ed and post-secondary ed.
- There was a lack of articulation among education programs and very few financial incentive programs existed.
- A total of \$450 million was set aside for WET.
- Collaboration among various agencies was instrumental in the development of the WET Program.
- The overall goal of WET is to develop qualified individuals for the public mental health workforce.
- The three main strategies to achieve this are: 1. Financial incentives. 2. Expand the capacity of psychiatrists and physician assistant training programs. 3. Provide technical assistance to counties.
- Incentivized programs are having a positive effect on the workforce.
- DMH is working with three medical schools to add psychiatric residents in public mental health.
- The physician assistant training program has impacted over 500 students to date.

- Technical assistance has been provided to counties, regional partnerships, the statewide technical assistance center and data collection analysis.
- A total of \$156 million has been approved for county WET implementation.
- A summary of state level activities is as follows: 1. A total of 1140 graduate students have received stipends. 2. There have been 598 mental health professionals awarded educational loan repayment contracts. 3. Approximately 600 medical students received training in MHSA principles. 4. Currently there are 45 counties implementing workforce plans.
- Under the WET Program there is money set aside for regional partnerships.
- Each of the five CMHD regions in California have \$1.8 million to address workforce development and deployment locally.
- Some of the program accomplishments are as follows: 1. First Rural MSW weekend program implemented. 2. Funding of online programs. 3. All regions are looking at core competency projects.
- Local programs have been able to make advances in spite of the challenging financial situation.
- There are five different funding categories that a county can choose: 1. Staffing. 2. Training and technical assistance. 3. Mental health career pathways. 4. Internships and residency programs. 5. Financial incentive programs.
- Calaveras County has had a recent drop in population because of foreclosures and people having to relocate.
- There is only one incorporated town in Calaveras County and that is Angels Camp.
- Public transportation is very limited.
- There is a growing Latino population in Calaveras County.
- The passage of MHSA brought back the children's system of care and created additional lived-experience positions and allocated a one-time amount of \$450,000.
- There are no colleges or universities within Calaveras County.
- An educational career ladder has been created to facilitate professional staff development.

- Two new psychology programs have been created at Columbia College.
- Curriculum has been purchased from the California Association of Social Rehabilitation Agencies (CASRA).
- Tuition assistance has been created at every level.
- Educational plans have been created to help individuals along their career paths.
- These measures have resulted in 40 percent of the mental health staff returning to school.
- Best practices and lessons learned in Calaveras County are as follows: 1. Academic advisors are needed. 2. Establishing rural mental health curriculum has been difficult. 3. Instructor shortages were compensated by using staff guest speakers. 4. Meeting with the schools is very important. 5. Internship/field placement has been a struggle.
- Team-based curriculum has been created that focuses on what the case managers need versus the clinicians and what the administrative staff needs.
- Mr. Mark Refowitz stated that Orange County is the most densely populated county in the state after San Francisco County.
- There are just under 1,000 county employees and well over 2,000 contract agency employees in Orange County's public mental health system.
- First and foremost the community through their MHSA planning process wanted to increase the number of peers and people with lived-experience in the workforce.
- Orange County wanted to make sure that 10 percent of the workforce was either peers or lived-experience in the mental health system.
- The big goal is to have 50 percent of the workforce comprised of peers or lived-experience personnel or consumers of services.
- Another goal was to increase the use of evidence-based practices.
- An important objective was to increase the participation in the workforce of individuals who come from ethnic and linguistic communities.
- A career ladder for people pursuing further education was also a goal.

- The number one strategy employed by Orange County was to employ agencies and strategies proven successful in other counties.
- Paid internships have been critical to the success of the program.
- For the past two years there has been a hiring freeze in Orange County.
- Appropriate services needed to be developed and delivered to consumers with co-occurring disorders.
- Services have been developed for returning veterans.
- A significant collaboration has taken place with Social Services of Orange County.
- Through the capital component some old county buildings will be demolished and Orange County is leveraging \$18 million to actually build a campus in the City of Orange to further the WET Program.
- Monies were allocated to be able to keep a significant number of fellows.
- A Center of Excellence for supporting recovery, improving health and reducing health disparities has been established and it is run by a psychiatrist who is a consumer and Vietnamese.

Questions/Answers and Discussion with the WET Panel

Ed Walker: Mr. Walker thanked everyone on the committee for their efforts on this component. A two part question was posed. 1. How much of the training is the focus of the county WET plans? 2. How much of the work plans, the development part of it is focusing on the administrative and the fiscal skill sets that have been in diminishing supply for well over a decade in public mental health and is there anyone thinking about doing something with MPA programs?

Answer: Mr. Refowitz responded by stating that even before the Act passed administration needed to start thinking about recovery and what does it mean. Orange County has taken steps to further define and ascertain what recovery actually equates to among consumers. The second thing has to do with making sure that managers have the skills so we have succession planning. Orange County has upped participation in the CIMH Training, its Leadership Academy. Ms. Thompson added that the short answer on the training is that all of Calaveras County's training funded by MHSA must fall under one of the five essential elements of the Act. And in regards to Mr. Walker's other question, of our 41 mental health staff, I have a cohort of five who are getting their fiscal education right now. And of our MSW students two are on an administrative tract as are several others in that program. Ms. Shilton stated that the program she mentioned in Colusa County, their financial incentive program was open all of their staff including staff in their business administrative pathway.

John Ryan: In the HR committee this morning there was some great county presentations about some very creative things they've done with their WET monies. We've come a long way from 10 years ago when this effort was started. Counties should be commended for being able to move forward in financially-stressed times.

Answer: Ed Walker mentioned that for a long time John Ryan was the lone voice among mental health directors for mobilizing CMHDA.

Joe Mortz: Where is the lived-experience person going to become certificated in the mainstream of funding?

Answer: Ms. Thompson replied that Calaveras County hasn't had any sort of consumer leadership movement up until the past two years. It's been key for the county to create stipend, volunteer positions because like other counties we are also under a hiring freeze.

Joe Mortz: I'm really advocating for HR to create training, certificated, licensed positions for people of lived experience to become fundable practitioners.

Brian Keefer: I think our goal is to create both a supported and supported employment atmosphere that allows any individual pursuing an education to be successful in that pursuit and for that certification or degree of completion or formalized degree or licensure to be portable. We also want to provide opportunities for folks who want to advocate and work locally to be in positions where they don't need to utilize formal education.

Marissa Lee: My question is about a potential blind spot in the WET Plan pertaining to Masters Level people who are no longer students but aren't licensed yet. My understanding is that post graduation people with an MSW degree have to have approximately two years of supervision hours in order to attain an LCSW and these positions aren't very highly paid. In Los Angeles County there is talk about making these hours completely unpaid. And the idea that someone can graduate with a Masters Degree and student loan debt but make less than some teenager working at McDonalds is mind boggling. It's not a living wage and then we're wondering why an MSW is considered unattainable by people who are low income or from a consumer background or from a minority community. This is why we're seeing that deficiency in the workforce. My question is, what can DMH do to make this career more attainable to people from those backgrounds particularly addressing the gap post-graduation but before licensure?

Answer: Mr. Keefer replied that DMH follows the same pathway that the Wellness Foundation, Endowment and other people have done with large, primary care providers and what you find the state and federal government involved in. And that's providing financial relief to our workforce either to stipend them during their educations and also setting up relief programs once they are employed. It's not until these last few years that we've been able to simultaneously launch statewide and the opportunity for local financial relief programs.

John Ryan: I thought that your basic statement (Ms. Lee) was that L.A. County is proposing that unlicensed social workers work for free. Is that what you're saying?

Marissa Lee: I was in a meeting and that was tossed around.

John Ryan: Well I think, and I don't know what a stronger word than, highly unlikely is, but whatever a stronger word than highly unlikely, most counties, all counties that I'm aware of have two classifications of social workers, unlicensed and a licensed and both of them are paid. I cannot imagine a county saying it will not pay its unlicensed workers, social workers, MFTs or whatever.

Marissa Lee: For a lot of TAY that are interested in this career path it just feels like a career path that you can't walk because of the current climate.

Lin Benjamin: I appreciated the comments about age-specific training that is happening. Because MHSA is funding age-specific programs I think it's very important that when we look at what the qualifications are of the public mental health workforce that we look at the degree to which they have age-specific competencies. I'd like to see that qualification elevated in the next steps of looking at the Five Year Plan. It's important the workforce have those special competencies to work with TAY, children and youth, older adults and adults because of their very unique and distinctive needs.

Susan Mandel:: We have made a lot of progress but this is not the time to relax. With health care reform looming ahead of us the estimated 30 million additional people covered will need behavioral health care and we have no where near the diversity, the lived-experience personnel and we have a lot of retirees coming up.

Daphne Shaw: I just wanted to say that Susan was talking about the need for a qualified workforce back in the mid 80's. At that time people couldn't do anything at the time.

6. Performance Indicators for Evaluating the Mental Health Services Act.

Ann Arneill-Py, provided the following report.

- A Dashboard for the evaluation of the Mental Health System has been developed.
- The Oversight and Accountability Commission has reviewed the indicators for evaluating the system and have signed on as supporters of the proposal.
- A prioritized set of indicators has been developed now referred to as “ a dashboard”.
- Three domains have been identified, 1. Education/Employment. 2. Homelessness/Housing. 3. Justice Involvement.
- Data is going to be produced for the first time using the Dashboard indicators.

Joe Mortz: There's no indicator regarding gay/lesbian, bisexual/transgender in this and I think that community needs assistance. The gay and lesbian community needs to be identified and included.

7. Report from the California Mental Health Directors Association.

Stephanie Welch made the following presentation:

- Associate Director Welch stated that the Conference Committee hopes to wrap up some of their hearings by the end of the week.
- One of the issues in conference is the issue around AB3632.
- AB 2645 is still alive and it freezes the IMD COLA on rates to the 2009 level.
- There was an additional \$1 million given to MHSOAC to increase their evaluation efforts.
- An additional \$800,000 was given to the California Health Interview Survey to improve mental health questions on the survey that they do.
- There have been discussions about the 1915 B Waiver in May revised hearings. One of the issues involved is ensuring that we really do have peer support as an allowable or billable service under our rehab option here in this state.
- Regarding the MHSA Housing Program it, has been a challenging effort for counties to implement. Because of the fiscal circumstances that even for those counties that have been very successful they really are and have expended any other options to fill up that operating reserve component.
- The Systems Development Committee should look at the performance of the program for small counties.
- CMHDA would like to recommend that the Human Resources Committee look at each of the eight state level contracts for stipends, loan assumptions and the things that have been discussed today and their accomplishments to see if they are still meeting the needs that we have in moving forward.
- The June 9th letter from the Council regarding advocating for the implementation of the measures in the Council's Crisis Residential Paper has been well received by CMHDA and they are starting discussions on it.

Karen Allen: I was wondering if CMHDA could comment on any legal consultation regarding AB 3632?

Stephanie Welch: I don't believe CMHDA has done any consulting in this regard. Our position is to fully fund or turn back the mandate.

Mark Refowitz: We in Orange County have consulted with counsel particularly the full litigant counties that filed suit prior.

Karen Allen: On 3632 I was just wondering when LAO mentioned moving the requirements to Education, did they mention moving the \$52 million with that and did they mention that that money is used to meet the match requirement for 1.2 billion in federal funds?

Stephanie Welch: I was not at the hearing. I was reading a summary of it. I think in the past the discussions have been that the funds are necessary to be there.

Joe Mortz: As a client/observer interested in Education but not participating in 3632 discussions, I have been saddened greatly by the lack of collaborative efforts at the policy and state level between Mental Health and Education. Clients and family members were not particularly welcomed in clinics or in policy meetings of Mental Health. And now evidence practices, community-based practices have shown that the participation of the community in policy and services is effective. It's therapeutic and efficient. I have a concern that the California Mental Health Directors Association doesn't meet in partnership or openness with the community as a policy board and I wish their meetings were open to the public.

8. Adjournment:

Chair Nickerson adjourned the meeting at 5:26 p.m.

Thursday, June 17, 2010

1. Welcome and Introductions

Chair Nickerson called the meeting to order at 8:33 a.m. Planning Council members and guests in the audience introduced themselves.

2. Committee Action Items

Children and Youth Subcommittee. No action items.

Transition Age Youth. No action items.

Adult Subcommittee. No action items.

Older Adult Subcommittee. No action items.

Cultural Competence Committee: No action items.

Policy and System Development Committee: No action items.

Human Resources Committee: No action items.

Quality improvement Committee: No action items.

3. Approval of the April 2010 Meeting Minutes

John Ryan mentioned that he thought the Committee was going to adjourn in Mike Oprendeck's honor for all the contributions he made to the Planning Council and he didn't note it in the minutes.

Tracy Thompson advised that the meeting was held in Mike Oprendeck's honor and the following was written on the April 2010 minutes under the Friday heading : *"This Meeting was dedicated to the memory of Solano County Mental Health Director Michael Oprendeck, LCSW, who passed away at work on April 7th. A Moment of Silence was held in his honor"*

Motion: The approval of the April 2010 Minutes was moved by *Ms. Cedro-Hament*, seconded by *Mr. Fry* and passed unanimously.

4. Approval of the Executive Committee Report

Chair Nickerson provided a synopsis of the Executive Committee Report:

- A number of action items were discussed and an update on AB 2234 was provided. The people determining the cost of the bill erroneously decided that this bill was going to cost millions of dollars. As a result it was put in the suspense file. The Council will reintroduce it with some rewording.
- Replicating the Mental Health Board and Commission Composition Study was voted on and approved and to report back to the county boards of supervisors any issues identified in the process.
- An additional staff member for the Planning Council was discussed. We have been provided penetration rates, retention rate data on 58 county mental health programs and we're also developing the Dashboard that we discussed yesterday. The request for a Research Program Specialist 2 was voted on and approved.
- There was considerable discussion about amending the legislative platform related to involuntary commitment and seclusion and restraint. We voted not to change the Council's Legislative Platform related to involuntary commitment. We did amend it regarding seclusion and restraint to support legislation that opposes that.

- We agreed that when any new legislation on involuntary commitment is developed it would warrant a discussion by the whole Council and a vote by all members rather than just a plank in our legislative platform.
- Lastly, we talked about strategic planning and we voted to spend two full days at the January meeting if we can arrange the rooms to discuss a five year strategic plan for the Council and then to spend Committee time at the following April meeting aligning the Committee activities with the plan that we develop. We're contracting with a state agency, the Center for Collaborative Policy, to facilitate our process.

Joe Mortz requested that the minutes show that during the discussion of the Executive Committee Meeting it was mentioned that three times in the last 10 years various forms of the issue of involuntary hospitalization have been voted on by this Council. And the Council has voted to oppose the involuntary hospitalization. I would like those votes to actually get documented. I believe that that was part of the conversation and I would like it to be part of the record of the minutes here that there was the belief that the Council has already three times voted as a whole Council, three times in the last 10 years in opposition to various forms of involuntary hospitalization.

Barbara Mitchell recollection was that the Council had voted to oppose involuntary outpatient commitment. And then we have taken action on issues having to do with seclusion and restraints. I don't recall a vote specifically on involuntary hospitalization just separately from the issue of involuntary outpatient commitment. So I don't feel that the Council has taken that position. In January will we be replacing all committee meetings or is this in addition or will we be spending the two days of the Council meeting on this? Will we be replacing all committee meetings?

Chair Nickerson: Yes. At the time when we have our two day planning, we will be replacing the committee meetings and part of our group meeting.

Daphne Shaw: The last instance was in relationship to outpatient, involuntary treatment but not hospitalization. We have previously had two votes that had to do with involuntary treatment and I cannot remember the exact details of them except that one time Karen Hart was the Chair and we talked about that particular issue and there was a previous one to that. So there have actually been three times when the issue of involuntary treatment has come before the Planning Council and the vote has consistently been to not to expand it in any way.

Karen Hart:: We had a panel of four people representing pros and cons. We did not have any vote. It was explained at that time that this was the first opportunity to hear from both sides of the issue. It would have been after that that there would have been a vote around that.

Motion: Acceptance of The Executive Committee Report was moved by Mr. Fry and seconded by Mr. Mortz and approved as submitted

5. Report from the California Association of Local Mental Health Boards and Commissions (CALMHB/C)

James L. McGhee, CALMHB/C President, reported that this would be his last report that he would give to the Council as President of the CALMHB/C. Mr. McGhee thanked the Board for the opportunity to have worked with them.

The California Institute for Mental Health joined with the CALMHB/C in preparing the regional training conferences.

There were three regional trainings held (June 2nd, June 15th, and May 22nd).

Within the past two years the CALMHB/C Board has made the system of infrastructure, systems and procedures work better.

Mr. McGhee thanked the officers for all their hard work.

Ms. Wilson was instrumental in updating the financials of the Board.

The CALMHB/C has a Manual of Operation.

The CALMHB/C has continued to move forward in spite of disagreements.

Elections are currently being held to elect directors and out of those directors the officers for the CALMHB/C will be elected.

The By Laws Committee successfully overcame some very difficult problems.

Mr. McGhee hoped that the newly elected officers would continue to move forward.

Susan Wilson: I wanted to thank everyone who has served on the CALMHB/C this year.

6. Report from the Mental Health Services Oversight and Accountability Commission.

Patrick Henning, Commissioner, provided the report.

- A few of the labor groups have reached some workplace harmony with the state.
- The MHSOAC is starting to focus more on its role as an oversight body.
- The CMHDA is planning on working with the CMHPC, the MHSOAC and others to identify some of the new and creative programs that have been funded because of the MHSA.

- The Workforce, Education and Training, at both local and regional areas, are being funded and counties are developing a new, creative and talented workforce as a result of that.
- Full Service Partnerships are the promise of what the MSHA was when it was voted in.
- The Petris Report addresses the subject of whether or not this will give you the full breadth of what the Act and what the Full Service Partnerships can provide.
- The MHSOAC is looking at whether Full Service Partnerships can work just as well for children and transition age youth.
- An important subject is what does it take for the counties to be able to enact the MSHA and the components that are left to them.
- An accountability framework will be implemented around children, youth and TAY and presentations will be made from the counties, the Alliance for Children and Family Services, the Youth Empowerment Network, some youth organizers from Humboldt County, Foster Age Youth as well as the United Advocates for Children and families.

John Ryan, commented that he wanted to know if there was a link to the Petris Report.

Ann Arneill-Py responded that the report hasn't been published yet but when it is she will get the information regarding the link and provide it.

Marissa Lee stated that she wanted to know the status of the MSHA Annual Update.

Commissioner Henning answered that the MSHA Annual Update is in the process of approval.

Marissa Lee wanted to know if the counties' annual updates will be approved by July 1st and if not, are there any consequences?

Commissioner Henning stated that he didn't believe that there were any consequences for not getting them published by July 1st.

Ms. Cabrera added that a total of 42 annual updates from the counties have been received and 23 have been approved. Until the county plans are received and approved, the DMH will not release any funds.

7. Public Comment

Andrew Phelps: Mr. Phelps stated that he was a client, survivor, activist from the 1960s. He currently teaches mathematics at De Anza College in Cupertino and he's active in the

group, Social Accountability Work Group of Client Survivors. Clinical Gaze deals with the subject of real transformation. In order for real transformation to take place the MHSa implementation has to move further forward than what is currently happening.

8. Crisis Residential Position Paper

Ms. Andi Murphy, Staff, gave the presentation. Some highlights:

- CMHDA helped us by putting out the word and helped us get a work group and the California Hospital Association was very helpful.
- A draft was put together and then there was a conference call to decide the strengths and weaknesses.
- The first question the paper asks is, if not crisis residential programs then what?
- The federal and state support for community beds was withdrawn and no alternatives were provided.
- California's average for beds is one bed for every 5,916. This does not include state hospitals.
- There are 25 California counties with no in-patient, psychiatric services.
- Crisis residential programs have been around for over 30 years.
- Peer respite programs have also emerged as promising practices.
- The outcomes with crisis residential programs are the same or better than psychiatric hospitals.
- The home life environment does prevent additional trauma at the time of personal crisis and it is adaptable.
- The actual cost effectiveness of these programs was the way to get the attention of the counties.
- As of June 2009 there were only 678 psychiatric, health facility beds in California in 19 counties.
- There are 432 beds in California in 18 counties.
- Crisis residential programs can serve as a diversion instead of taking people to the emergency room..

- MHSA funding is available right now and it is also some of the only funding that welcomes progressive, forward-thinking programs that promote wellness, recovery and healing in your own community.
- Some federal incentives are the National Healthcare Reform and the state plan amendment and the 1115 waiver is being re-written.
- The Olmstead Decision in 1999 and the Community Residential Treatment Systems Act of 1978 mandate least-restrictive settings.
- The American with Disabilities Act and the Fair Housing and Employment Act both prohibit discrimination.
- The three funding components that can be applied:
 - Capital facilities for finding a structure or location or a base to work from.
 - CSS funds to pay for the services.
 - Innovation funds which would help develop additional programs or expand programs.

Some Recommendations: 1. To request or use MHSA funds to create additional crisis programs and peer-run respite centers. 2. To advocate through the 1115 Waiver Proposal to include crisis residential programs as medical homes. 3. Improve the existing performance indicators and data collection to document the effectiveness of these programs. 4. DMH should produce and post data showing the expenditures for 24 hour modes of service by county annually. 5. DMH should create a resource directory for those wishing to establish crisis residential programs in their communities.

Questions/Answers, Discussion with Ms. Murphy.

Adrienne Cedro-Hament: I have a suggestion that the recommendations that you have stated be given to the Policy and System Development Committee.

Joe Mortz: I think all committees should look at this but it's ready for approval by the Council today and I think it should be adopted.

Chair Nickerson: It's been approved Joe.

Joe Mortz: I'd like to hear from the Hospital Association and I'd also like to know what MHSA money can go in besides service. Is it just capital?

Answer: Ms. Murphy stated that the capital funds could be used to find a structure or a building that could be used and then CSS funds could be used to help pay for the services

and then also innovation monies could be used towards that too, particularly for peer-run respite-type programs.

Joe Mortz: On the data outcome I'd like the Council to hear about a book that was written called, *Mad in America* by Robert Whitaker. It's a history of treatment in the United States. Residential treatment outcomes were much superior to medication. In the last two years there have been a number of studies that have come up.

Sheree Kruckenberg: Ms. Kruckenberg of the Hospital Association mentioned that in October of 2008 or 2009 a panel of hospital representatives came and spoke to the Planning Council and one of our recommendations was an increase in the number of crisis residential treatment settings. We struggle mightily with data. Hospitals by and large not only believe in crisis residential we also believe in true crisis services so data is a big piece.

Renee Becker: On page two you referred to Transitional Age Youth (TAY) and on page five you mentioned adolescents. With regards to age group, when you say adolescents and TAY is this 18 and above because it's residential care? I'm wondering how do children fall into this?

Answer: Ms. Murphy replied that it was more of a general observation that because of the flexibility of the programs that they were particularly well suited for services for youth or transition age youth that right now increasingly are becoming institutionalized more often because there's no appropriate setting for them to be in.

Renee Becker: So this recommendation could be TAY because it does get confusing with the MHSA on the transitional age when they talk about age or adolescents. So this could be all ages?

Answer: Ms. Murphy - I believe so. I don't know why not. I don't think you would have mixed age groups in one home. You could certainly have programs that were geared towards specific age groups.

Marissa Lee: And this might be a semantics issue. Adolescents are generally people under the age of 18 rather than the TAY.

Daphne Shaw: I'd just like to comment that I actually sat on the CRTS Committee or the Residential Treatment System Committee back in the early 1980s. Even at that time it was difficult to bring about at the Community Residential Treatment System and at that time it was categorical money. It sort of forced counties to put in place some of these programs in the system. This paper is an effort to try and educate people about the fact that the system even exists.

Steve Leoni: I entered a residential treatment program way back in 1976 and I wound up staying there as a volunteer for 25 years. Assemblyman Tom Bates introduced the Community Residential Treatment Systems Act in 1978. The original roots of this act

goes way back into the 60s. The crisis residential starting addressing the problem of people going into the inpatient, coming out again, coming into the inpatient and coming out again and needing something to help them transition and get past that. Barrier disbelief is the reason the model didn't spread. It's beginning to spread now because everybody is talking about recovery and you can do voluntary services but for a long time people didn't believe the programs could actually work. They believed consumers had to be in the hospital or in board cares.

9. Brainstorming New Planning Council Theme

Chair Nickerson: Since we've decided to go ahead and do strategic planning in the next six months or so we're going to skip this topic.

10. New Business

Adrienne Cedro-Hament asked what happened to the idea of having a brochure for the Planning Council.

Chair Nickerson responded that it was still pending and thanked Ms. Cedro-Hament for reminding the Council about it.

George Fry commented that he recommended at the Executive Committee Meeting that a panel be convened in Sacramento in October on veterans. The panel would consist of a psychiatrist, a psychologist, a clinical social worker from the VA Hospital in Palo Alto, a family member of a veteran and a veteran.

John Sturm: Mr. Sturm has been concerned about the residents in San Diego because of all the earthquake activity lately. He was concerned about whether or not they had enough emergency materials on hand to sustain what they would need for the three days that they might need to in case of an emergency. Volunteers and donations are being put together.

11. Adjournment

Chair Nickerson adjourned the meeting at 10:21 a.m.