

California Mental Health Planning Council

Advocacy Committee - REVISED

Wednesday, May 11, 2016

1501 Capitol Avenue
3rd Floor
Sacramento, Ca 95814
Conference Call Capability Available

**Dial 1-877-580-9104 participant code 2763421
10:00 a.m. to 11:30 a.m.**

Time	Topic	Presenter or Facilitator	Tab
10:00 am	Welcome and Introductions	Darlene Prettyman, Chairperson	
10:05	Agenda Review	Darlene Prettyman	
10:10	Finalization of the 2016 Policy Platform Draft	Darlene Prettyman and All	A
10:35	Work Plan Format Draft Discussion	Darlene Prettyman and All	B
11:00	PC Letters: AB 1884 Remove from Suspense file support; Housing Principles Sign-on	Darlene Prettyman and All	C
11:25	Public Comment	Darlene Prettyman and All	
11:30 am	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

Staff: Dorinda Wiseman

If reasonable accommodations are required, please contact Chamenique Williams at (916) 323-4501 within 5 working days of the meeting date in order to work with the venue.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

LEGISLATIVE PLATFORM

January 2016

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

The statements below are the Council's guiding principles.

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

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

The statements below are issues the Council is in the process of deliberating on for future consideration.

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

ADVOCACY COMMITTEE WORK PLAN

2015-2017

1. Goal Statement:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
<p>Report on logistical, fiscal and/or programmatic efforts being made to transition people out of IMDs. If none, what challenges are experienced in doing so.</p>	<p>Support Council focus on Alternatives to Locked Facilities. Federal Public Law (PL) 106-310- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772.</p>	<p>~IMD data will be provided by DHCS, possibly April 2016; ~Staff will attempt to obtain data on the impact of IMD closures.</p>
<p>End Product/Target Audience/Expected Outcomes:</p>	<p>Intentionally Blank</p>	<p>Intentionally Blank</p>
<p>~ An IMD stand-alone report, separate from the Alternative to Locked Facilities, report will be released with the findings January 2017. Additionally, it will be provided to stakeholders, legislators, DHCS and local Mental Health Boards.</p>	<p>Intentionally Blank</p>	<p>Intentionally Blank</p>

ADVOCACY COMMITTEE WORK PLAN

2015-2017

2. Goal Statement:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
<p>Look into closures of Residential Care Facilities in California, qualitative and quantitative data.</p>	<p>Federal Public Law (PL) 106-310- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772(2) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs, and (5) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.</p>	<p>~Obtain data on the Levels of Care Statistics on closures, length of stay, flow of transition for individuals utilizing RCFs; ~Provide recommendations for statewide changes (e.g. Prohibition of Centralized medication Storage, etc.) ~Identify why people are in the various levels of care and the flow through them. ~Research the financial viability of the models. ~Research any alternative or innovative housing options.</p>
<p>End Product/Target Audience/Expected Outcomes:</p>	<p>Intentionally Blank</p>	<p>Intentionally Blank</p>
<p>~A draft report will be submitted to the PC in October 2016</p>	<p>Intentionally Blank</p>	<p>Intentionally Blank</p>

ADVOCACY COMMITTEE WORK PLAN

2015-2017

3. Goal Statement:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
<p>Follow-up Report on the implementation of AB 109, Criminal Justice Realignment, amongst Los Angeles, Santa Clara, San Mateo, Stanislaus and Ventura Counties.</p>	<p>Support Council focus on Alternatives to Locked Facilities. Federal Public Law (PL) 106-310- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772.</p>	<p>~Obtain information from the four counties' progress made, since the 2012 report was released. ~Work collaboratively with DHCS, COMIO, BSCC and other policy/research entities vested in the AB 109 community.</p>
<p>End Product/Target Audience/Expected Outcomes:</p>	<p>Intentionally Blank</p>	<p>Intentionally Blank</p>
<p>~A comparison report will be released October 2016. ~The target audience includes stakeholders, legislators, the DHCS and local Mental Health Boards.</p>	<p>Intentionally Blank</p>	<p>Intentionally Blank</p>

ADVOCACY COMMITTEE WORK PLAN

2015-2017

4. Goal Statement:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
Report on Children and Youth (2016-2017) involved in the Juvenile Justice System.	Support Council focus on Children/Youth. Federal Public Law (PL) 106-310- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772. Focus on Children and Youth with the Juvenile Justice System.	~Obtain data on Children and Youth receiving MH/SUD Treatment within the State (Jan.2017); ~Obtain data on Children and Youth placed Out-of-Home (Jan. 2017); ~Obtain data on Children and Youth placed Out-of-State (Jan. 2017); ~Demographics on the treatment availability (Jan. 2017); ~Data on Outcome Measures (Jan. 2017)
End Product/Target Audience/Expected Outcomes:	Intentionally Blank	Intentionally Blank
~A report will be released to stakeholders, legislators, CDSS, CDCR andby October 2017.	Intentionally Blank	Intentionally Blank

5. Parking Lot:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
Future Issue warranting discussion or action.	Intentionally Blank	Intentionally Blank
End Product/Target Audience/Expected Outcomes:	Intentionally Blank	Intentionally Blank
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DRAFT



May 5, 2016

Honorable Lorena Gonzalez, Chair
Assembly Appropriations Committee
State Capitol, Room 2114 Sacramento, California 95814

AB 1884 (Harper) Mental Health License Plates- Support to Remove from Suspense

CHAIRPERSON
Josephine Black

EXECUTIVE OFFICER
Jane Adcock

On behalf of the California Mental Health Planning Council (Council), I am writing in request of your support in removing AB 1884 out of the Suspense File. This bill would allow the Department of Health Care Services to apply to the California Department of Motor Vehicles for the creation of a license plate to raise awareness for mental health. The plate will bear the lime-green ribbon associated with mental health advocacy and a phrase such as "Mental Health Matters." There will be no cost to the State related to the license plate as the presale of 7,500 of these specialty mental health license plates will cover all expenses. There is growing community support for this license plate and there are commitments from thousands of people already to pre-purchase them.



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Since 2011, California, through the California Mental Health Service Authority (CaMHSA), has implemented a comprehensive statewide mental health promotion and mental illness prevention initiative that uses institutional, community, and individual strategies to eradicate the negative consequences associated with stigma such as: reduced and delayed help-seeking, loss of opportunities (educational and vocational), and increased chronic physical health conditions. As a way of organizing these efforts, disseminating Prevention and Early Intervention tools/resources and creating a statewide mental health movement, CALMHSA created Each Mind Matters in 2013. The Council is committed to eliminating stigma associated with mental health; we strongly believe that this measure will go a long way towards creating positive awareness for mental health by promoting hope and recovery. It is for these reasons that the Council respectfully requests that AB 1884 be removed from the Suspense File.

If you have questions, please do not hesitate to contact First Name, Last Name, at (916) 323-4501 or at FirstName.LastName@email.com.

Sincerely,



Behavioral Health Housing Principles

Expanding safe and affordable housing is a key priority for the undersigned behavioral health providers and advocates. County behavioral health departments, community based providers, family members and mental health service consumers are essential partners in any effort to reduce and prevent homelessness when mental illness and/or substance use are key contributing factors. A safe place to call home is essential for personal recovery and wellness, and behavioral health services are critical in preventing homelessness. Based on our experiences, we strongly believe the following principles must be considered in designing new efforts and targeting new investments:

1. Utilize the Public Behavioral Health Target Population Definition for Homelessness Prevention and Reduction Efforts

In public behavioral health, Mental Health Services Act (MHSA) funded supportive housing is targeted for people who are low-income and who are homeless or at risk of being homeless.* All proposed housing programs funded with MHSA funding should use the following criteria for eligibility:*

□ DHCS has defined the MHSA Target Population for the purposes of the MHSA Housing Program, as individuals who meet the following criteria:

- ❖ (1) Adults or older adults with serious mental illness as defined by Welfare and Institutions Code Section 5600.3(b).
- ❖ (2) Children and youth with severe emotional disorders as defined in Welfare and Institutions Code Section 5600.3(a).
- ❖ (3) In addition to meeting either (1) or (2) above, the individual shall be one of the following:
 - Homeless, meaning living on the streets or lacking a fixed and regular night-time residence. This includes living in a shelter, motel or other temporary living situation in which the individual has no tenant rights.
 - At risk of being homeless due to one of the following situations: (i) Transition age youth exiting the child welfare or juvenile justice systems. (ii) Discharge from crisis and transitional residential settings; a hospital, including acute psychiatric hospitals; psychiatric health facilities; skilled nursing facilities with a certified special

rehabilitation centers. (iii) Release from city or county jails. (iv) Temporarily placed in a residential care facility upon discharge from (ii) or (iii) above. (v) Certification by the county mental health director as an individual who has been assessed by and is receiving services from the county mental health department and who has been deemed to be at imminent risk of being homeless.
• The county mental health department determines the eligibility of individuals applying for tenancy in an MHSA unit in compliance with the target population criteria.

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It is important to maintain this criteria, rather than the more stringent federal criteria, to enable housing programs to serve individuals who have been in treatment programs, or who have been incarcerated and who are returning to the community. This serves to prevent these persons from becoming homeless.

~~** A person who lives on the streets or lacks a fixed and regular night time residence is considered homeless. The target population is further defined as adults, older adults, transition age youth with serious mental illness, children with severe emotional disorders and their families, who at the time of assessment for housing services meet the criteria for MHSA programming. Use of MHSA funding must be consistent with the voter mandate.**~~

2. Utilize Strategies That Prevent Homelessness

Often, individuals living with serious mental illness cycle through the criminal justice system without an appropriate behavioral health diagnosis or treatment. Re-entry planning should include behavioral health services, as well as supportive housing, in order to prevent homelessness. Additionally, for individuals who receive behavioral health treatment in hospitals, discharge planning should include ensuring a stable place to live in addition to linkages to behavioral health services. Partnerships between social service providers, behavioral health providers, law enforcement, family members, and consumers are important to prevent homelessness in the target population.

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~~3.2. Utilize Proven Models To Respond to Homelessness~~

Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – while providing supportive services. This approach posits that having a roof over one’s head is an essential step in reducing homelessness while acknowledging the many mental health and substance use challenges that prevent the homeless from accepting assistance. *However, there are other models that are suitable that should be included in any housing developed using MHSA funds. Transitional and emergency housing are models that may be more effective with some persons who are not ready to commit to permanent housing options or who may need more intensive services before they can manage a permanent housing setting.* Rapid Re-housing rapidly connects families and individuals experiencing homelessness to permanent housing. Efforts should also be made to ensure that individuals in temporary and bridge housing are targeted for permanent, supportive housing (i.e., not just those individuals who are homeless). ~~**Programs should also support housing provided by caregivers to individuals living with mental illness.**~~ A variety of proven strategies should be considered in any investment to end *and prevent* homelessness.

~~4.3. Invest in Supportive Services and Break the Cycle of Long-Term Homelessness~~

Supportive services, for people with behavioral health challenges, are essential to housing stability and to maximizing each individual’s ability to live independently. County Behavioral health departments are uniquely positioned to identify and intervene - in collaboration with community partners, family members, and consumers - to address the dual, interwoven, public health crises of substance use and mental illness that complicate homelessness. A successful strategy to combat homelessness will build on local and statewide collaborations and include essential mental health and substance use services.

~~5.4. Fund Construction, Operating Subsidies, and Supportive Services~~

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Construction is only one of the *three* major costs to permanent supportive housing. Equally important is funding to make up the difference between what it costs to operate the housing – such as paying for maintenance, property management and other employees, or a new roof -- and what residents can afford to pay. Most homeless individuals lack income beyond a monthly check provided under federal Social Security programs for people with disabilities and could not afford the rent of an apartment without a subsidy. Therefore, in order to maintain appropriate living standards in the housing units, and to make the units affordable for the tenants, the units must be subsidized through a capitalized operating reserve or some other form of subsidy. And finally – supportive services including mental health and substance use are essential. *However, support services should not be funded through any bond proceeds.*

6-5. Ensure Residents of All Counties Can Benefit from Additional Housing Investments

Homelessness impacts all counties. Therefore, any MHSA funds set aside for the purpose of expanding housing capacity should be available, through a noncompetitive process, to all counties to invest in additional housing and supportive services. Stakeholder involvement is a key tenet of the MHSA, and counties investing in additional housing and supportive services will maintain robust stakeholder processes in the planning of any new programs. Any additional investments should be accompanied by evaluation measures and funding to support outcome-based evaluations.

7-6. Balance Investment

Counties and providers are working diligently to achieve the goals of the MHSA which calls for more expansive, inclusive, effective, innovative, and an accountable mental health system. Every dollar devoted to a statewide approach to housing is a dollar that will not be spent providing direct mental health and substance use services at a time of overwhelming need. There needs to be a balance between investing in affordable housing and investing in other critical mental health and substance use services.

8-7. Consider MHSA Revenue Volatility

MHSA funding allocations are not consistent each year. The annual amount of MHSA funding diverted for housing needs to be adjusted and matched with the volatility of the revenue source and each county should be able to determine what funding is used to pay back any bond debt (e.g. Prevention and Early Intervention (PEI), Innovation, Community Services and Supports (CSS), funds at risk of reversion or new funding). In addition, there needs to be a consideration given to fund services *in the long term* to people living in permanent supportive housing created by any statewide program as well as funding for long term operating costs of maintaining housing.

9-8. Ensure Flexibility to Address Local Needs

There is not a “one size fits all” approach to housing across the State; there are a number of housing models for supportive housing. The housing setting can vary and is based on a range of factors including the resident’s preference, the type of housing available, affordability, and the history of a local community’s real estate market. For example, in cities, large apartment buildings are typical while in suburban and rural communities; single-family homes are more common. Programs need flexibility with regard to the utilization of housing such as options for Master Lease agreements and housing rehabilitation, in addition to capital investments. Additionally, California is a diverse state and programs

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must be culturally appropriate and able to meet the needs of each community. *** (I question the viability of master leases unless it's a 40 year lease, if we are putting capital costs into a building.) ***

10.9. Address “Not in My Backyard” (NIMBY) and Siting Challenges

Organizations that provide housing and supportive services to people with mental health and substance use disorders have tremendous challenges including identifying housing sites, obtaining necessary funding, arranging for services, navigating complex administrative systems, and securing scarce funding sources even when neighbors and local government support the project. The process becomes far more difficult when neighbors protest about housing “those people” in “our” neighborhood. Any statewide housing initiative should support efforts to reduce stigma and housing discrimination against people with mental health and substance use challenges. ***In addition, NIMBY issues should be addressed by using both state and federal laws that prevent discrimination in housing. Training for developers in these laws, as well as training for local government entities that control development, zoning etc, should be included in any initiative.***

11.10. Leverage and Increase the Impact of Existing and Emerging State Housing and Services

The MHSA Housing Program developed in August 2007 set aside \$400 million in funds to provide capital development loans and critical funding for long term operating subsidies for the development of affordable rental housing for MHSA individuals. Each county’s Department of Mental Health provides MHSA residents with an *individualized array of supportive services* needed for recovery and the opportunity to become fully functioning community members. These program funds are administered for counties by the California Housing Finance Agency (CalHFA) and the California Department of Health Care Services (DHCS). The funds from the MHSA Housing Program will ultimately house approximately 2,600 MHSA residents. Several counties plan to continue the partnership and assign additional MHSA dollars to CalHFA to administer under a new statewide program. Additionally, as authorized under the Affordable Care Act, States can create “Health Homes” to serve individuals with chronic conditions including mental health and substance use. One of the primary goals of the Health Home Program in California is to link individuals to housing and services. This is another opportunity to address the needs of the homeless. Aligning with initiatives such as these is imperative.

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