

# CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

January 17 and 18, 2013  
Courtyard San Diego Mission Valley/Hotel Circle  
595 Hotel Circle South  
San Diego, CA 92108

## CMHPC Members Present:

John Ryan, Chair (Thursday only)	Dale Mueller
Beverly Abbott	Monica Nepomuceno
Patricia Marrone Bennett, Ph.D.	Adam Nelson, M.D.
Josephine Black (Thursday only)	Gail Nickerson
Adrienne Cedro-Hament	Jeff Riel
Cindy Claflin	Joseph Robinson
Michael Cunningham	Daphne Shaw
Doreen Cease	Walter Shwe
Amy Eargle, Ph.D.	Stephanie Thal
Nadine Ford	Cheryl Treadwell
Lorraine Flores	Jaye Vanderhurst
Steven Grolnic-McClurg	Chloe Walker
Karen Hart	Bill Wilson
Celeste Hunter	Monica Wilson, Ph.D.
Carmen Lee	Susan Wilson
Terry Lewis	Sandra Wortham
Barbara Mitchell	

## Staff Present:

Jane Adcock, Executive Officer	Andi Murphy
Linda Dickerson	Narkesia Swanigan
Mike Gardner	

## Thursday, January 17, 2013

### 1. Welcome and Introductions

Chair John Ryan brought the meeting to order. He requested new Planning Council members, as well as continuing members, to give thumbnail sketches of themselves.

**Gail Nickerson** works with clinics on the primary care side. She is a Consumer Related Advocate.

**Barbara Mitchell** has been on the Planning Council since 1999, and is the director of a non-profit mental health agency in Monterey County. She is active in affordable housing issues.

**Patricia Bennett, Ph.D.**, is the CEO of Resource Development Associates in Alameda County, which does planning and evaluation in conjunction with city, county, and state governments.

**Jeff Riel** is the Assistant Deputy Director for Collaborative Services with the State Department of Rehabilitation.

**Daphne Shaw** of San Joaquin County represents the California Coalition for Mental Health. She has served on the Planning Council since 1991, and served for 30 years on her county Mental Health Board.

**Karen Hart** represents Families of Youth. She has served on the Planning Council since 1995. She is a founding member of United Advocates for Children and Families, and also sat on her county Mental Health Commission for many years.

New member **Lorraine Flores** works as Associate Director for the Bill Wilson Center, a nonprofit mental health agency. She oversees QA and QI and works on outcomes.

**Monica Nepomuceno** oversees the Mental Health Services program for the California Department of Education. Prior to that she was a school social worker for 14 years. She is a Consumer and Family Member.

**Susan Wilson** of Shasta County is a Family Member. She also runs two programs: a substance abuse prevention program and a youth peer court for teens in trouble.

New member **Amy Eargle** is the Chief Psychologist with the Department of Corrections, and is in charge of the Clinical Support Unit. She is also a Family Member.

**Walter Shwe** is a Direct Consumer from Yolo County. A past Planning Council Chair, he serves on the Board of Directors of the National Alliance on Mental Illness (NAMI) Yolo County.

New member **Chloe Walker** is a Direct Consumer and Family Member as well. She is a professional advocate, working with the California Youth Empowerment Network (CAYEN). Foster care is her primary interest.

**Nadine Ford** represents the State Department of Housing.

**Michael Cunningham** is the Acting Director with the California Department of Alcohol and Drug Programs. He finds it of critical importance for this department to be well-represented on the Planning Council, because of the relationship between alcohol/drug and mental health issues.

**Linda Dickerson, Michael Gardner, Narkesia Swanigan, Andi Murphy** are Planning Council staff.

**Jaye Vanderhurst** is a Provider Member. As the Napa County Mental Health Director, she represents the California Mental Health Directors Association. She also has 25 years of experience at the Department of Mental Health.

New member **Terry Lewis** is the Executive Director of the Los Angeles County Mental Health Commission. Her chief interests are public policy and advocacy.

**Cindy Claflin**, from the United Advocates for Children and Families, is the Director of the Institute for Parent Leadership Training. She serves on the Planning Council as a Family Member and Parent.

New member **Bill Wilson** has been a consumer for 30 years. He is an AA member, a church member, and a volunteer at Long Beach Mental Health.

**Adrienne Cedro-Hament** of Los Angeles County has been involved with advocacy since arriving in this country in the 1970s. She is a long-time member of the Planning Council and advocates for cultural competency services for ethnic minorities.

**Celeste Hunter** is a Family Member, representing children, youth, and families. A member of the Planning Council since 1997, she has also been a family advocate for over 30 years, working in special education and mental health. She is a certified Grief Recovery Specialist and works with families who have lost loved ones to violence.

**Beverly Abbott** has worked in mental health for many years, in the State Hospital, as a Mental Health Director, with the MHSA implementation for the State Department of Mental Health, and currently in Telecare preparation. She is a Consumer Related Advocate who has served on the Planning Council for 12 years.

New member **Sandra Wortham** is a Family Member with a son who is a Bill Gates Millennium Scholar at Columbia University.

**Adam Nelson, M.D.**, is a psychiatrist in Mill Valley with 23 years in practice. He represents the California Psychiatric Association. On the Planning Council his main interest is advocacy for access to care.

**Stephanie Thal** is a licensed Marriage and Family Therapist, and she is a Provider Member. She has served on the Planning Council for eight years and lives in Kern County.

**Dale Mueller, R.N.**, serves as a Provider Member. She has worked in community-based services as an administrator and program developer, and as a nurse in school systems and prisons. She is now a tenured faculty member in the School of Nursing at the largest minority-serving school in the California State University system.

New member **Joseph Robinson** is a Provider Member. He is a clinical social worker and has been a certified substance abuse counselor for over 20 years. He works with the California Association of Social Rehabilitation Agencies (CASRA), mostly regarding public policy.

**Monica Wilson, Ph.D.** is a Consumer Related Advocate from San Bernardino County. She has worked as a Vice-President of Children and Mental Health Services for the National Mental Health Association. Currently she is Vice-Chair of the Behavioral Health Commission in San Bernardino County.

**Carmen Lee** from San Mateo County is a Consumer Representative. She is the Director of Stamp Out Stigma, a program that reaches into national and international audiences.

**Jane Adcock** is the Executive Officer for the Planning Council. She welcomed new members and thanked them for coming to the meeting on such short notice.

**John Ryan**, now retired, was a County Mental Health Director for many years. He was also pleased to welcome the new members with their wealth of backgrounds and experience.

Chair Ryan relayed the information that John Black had found himself dealing with the combination of a job promotion and ill family members, and had to pass on the position of Chair a little early to John Ryan.

## **2. Opening Remarks**

Chair Ryan welcomed Alfredo Aguirre, Director of the San Diego County Mental Health Board.

Mr. Aguirre acknowledged the momentum the Planning Council members may be feeling as a result of President Obama's unveiling of his plan to reduce firearm violence, and the associated mental health improvement objectives. He noted that thanks to the Mental Health Services Act (MHSA), California counties are a step ahead of the rest of the country in relation to the recommended services: mental health first aid, school-based mental health, specialized outreach services to certain populations, and so on.

California has a relatively rich mental health benefit package for Medicaid beneficiaries, but the state has a long way to go as it looks at the Affordable Care Act. The President's plan encourages us to take advantage of the opportunity to comply with the federal parity legislation, and expand behavioral health care. It is essential that the health plans in our state ensure access and better practice strategies that will prove to be more successful.

Since the Planning Council last met in San Diego, the county has undertaken a variety of efforts:

- It has furthered the efforts to integrate at program and administrative operation levels.
- It has begun to integrate its Alcohol and Drug Advisory Board and its Mental Health Board.
- It is working closely with the health plans to make sure that there is a seamless transition of Healthy Families beneficiaries to Medi-Cal.
- It is preparing for KDA, the court-related initiative to enhance the system of care for foster youth.
- It is advancing integration of primary care and behavioral health.
- The county's political winds have shifted: it has a new Democrat mayor and its first Democrat on the Board of Supervisors.
- The county is prepared to work with the city to address the needs of the homeless population.

In closing, Mr. Aguirre wished for the Planning Council to have a great meeting.

Chair Ryan requested audience members Beryl Nielsen and May Farr to introduce themselves.

### **3. Approval of the Minutes of the October 2012 Meeting**

**Motion:** The approval of the October 2012 Meeting Minutes was moved by Susan Wilson, seconded by Monica Wilson. Motion passed with seven abstentions.

### **4. Election of Chair-Elect**

Speaking on behalf of the Nominating Committee, Ms. Nickerson stated that the chosen Chair-Elect is Monica Wilson.

**Motion:** The election of Monica Wilson to the position of Chair-Elect passed by a unanimous vote.

### **5. Executive Committee Report**

Gail Nickerson, Committee Chair, reported that the Executive Committee had agreed on its composition: Chair, Chair-Elect, Past Chair, Executive Officer, Chairs of each of the four committees, a liaison to CMHDA, a liaison to the Administration, and an at-large. The Executive Committee is referring the designing of its function to the Operations Workgroup.

The Executive Committee has decided that at each meeting, one of the four committees will be featured and will have an extended amount of time to present its work in depth. Because the topic of health care reform is currently at the forefront of the news, the Health Care Reform Committee will be the first to present an extended report, at the April meeting.

An evolving and emerging issue is who holds the leadership role at the state level regarding mental health. The Executive Committee will continue looking into this, by having conversations with the Department of Health Care Services (DHCS) and CMHDA.

Mr. Ryan reported that he had asked Ms. Nickerson to assume the position of Past Chair.

He continued that when correspondence goes out from the Planning Council, the names of the committee and Committee Chair who have done the work should appear at the bottom of the letter, along with the name of the Planning Council Chair to indicate that the whole council has approved it. Mr. Ryan has directed staff to act accordingly.

Executive Officer Adcock referred the Planning Council members to a new “Schematic for Planning Council Functions” produced by Ms. Murphy.

She referred the Planning Council members to a new form from the Fair Political Practices Commission and explained how they should sign. She then explained the rest of the packet contents.

Mr. Gardner explained the Fair Political Practices form in further detail and cautioned the Planning Council members to take the form seriously to avoid a possible fine.

### **6. Committee Reports**

#### **Patients’ Rights Committee**

Committee Chair Daphne Shaw reported that last year the Legislature had given the Planning Council the responsibility to establish this committee to examine issues around patients' rights.

The committee will consist of five members from the Planning Council and two Ad Hoc members. The Planning Council members are Gail Nickerson, Walter Shwe, Cindy Claflin (Vice-Chair), Neil Adams, and Carmen Lee. They decided to have teleconferences during the months that they do not meet.

At this point the committee suspects that much of its work will occur outside of the Planning Council quarterly meetings.

Mr. Gardner had put together a draft Mission Statement that the committee is wordsmithing.

The committee is considering whom to contact to become the Ad Hoc members.

Part of the committee's charge is to report on patients' rights issues to both the Department of Health Care Services (DHCS) and the Department of State Hospitals. They will begin by obtaining performance contracts from a variety of counties to examine.

Ms. Nickerson read California Welfare and Institutions Code 5514, which charges the Planning Council with establishment of the Patients' Rights Committee.

Ms. Abbott asked whether the Planning Council has sufficient funds for that committee to meet outside of the quarterly meeting. Executive Officer Adcock responded that the five members had decided not to leave their other committees, and to set their meeting time for lunch during the full Planning Council meeting day. They may still adjust their meeting time.

Ms. Nickerson stated that no additional money had come along with the mandate. In the future the committee may visit state hospitals and counties – they may be coming together at times outside of the quarterly meetings.

### **Health Care Reform Committee**

Committee Chair Beverly Abbott welcomed three new members – Terry Lewis, Suzy ??? and Joe Robinson – who are very interested in the subject.

The committee is involved in a demonstration project about people who are dually eligible for Medicare and Medi-Cal; eight large counties will participate. These people will go into a managed care plan that has both Medicare and Medi-Cal money. The planning phase is complete. The implementation phase will last from January to June, with an ongoing monitoring phase after that.

The Planning Council's interest has been what really happens in the project. The committee has picked overarching themes with which to monitor this project (and all of health care reform): stakeholder involvement and the core values of the MHSA.

Jaye Vanderhurst is taking the lead on tracking the Medi-Cal expansion component, where in 2014 many more people will become eligible for Medi-Cal and different kinds of insurance. The part of the expansion that she had focused on was the California

Mental Health and Substance Use Needs Assessment. Finalized in February 2012, it was submitted to DHCS because it becomes the foundation for them to develop the Behavioral Service Plan.

The Needs Assessment Report is over 300 pages long and is rich in data. It describes the current strengths of the system, as well as the gaps and targets. The Health Care Reform Committee will diligently track how DHCS is using the Needs Assessment to develop the Behavioral Service Plan, due April 1, 2013.

The Needs Assessment Report is available on the DHCS website under Behavioral Assessment/1115 Waiver.

Ms. Abbott felt that DHCS has done a good job with their stakeholder process in terms of notification. The one thing missing is time for stakeholders to get together with DHCS.

Cindy Claflin is taking the lead on tracking children's issues. In preparing for budget reform, the Governor's Budget last year took all children out of Healthy Families. Ms. Claflin reported that Erika Cristo of DHCS had talked with the committee about the transition for these children.

The committee had been interested in rural area transition. Most of the phases are supposed to be completed by June. However, Phase 4 – Fees for Service – is the one that will cover those children in the rural areas.

Ms. Cristo and the committee also discussed children with Severe Emotional Disorders (SED). Those children will have to be reassessed to see if they can go out of Medi-Cal into the mental health system. The committee is concerned about what the assessment will look like. Ms. Abbott added that the committee will be tracking DHCS's performance metrics as well.

Ms. Abbott stated that there is a good interface in terms of workforce issues in the Behavioral Health Needs Assessment. Dale Mueller will be reporting on that.

For the Health Care Reform Committee's presentation at the April meeting, Ms. Cedro-Hament requested information about the underserved population. Ms. Abbott noted that 11% of the uninsured population in California will remain uninsured under the Affordable Care Act; they are mostly people who are undocumented.

Ms. Bennett suggested that a glossary of terms would be useful for the Planning Council. Ms. Abbott responded that the committee will supply a list of component definitions in April. Ms. Cedro-Hament noted that the Los Angeles County Department of Mental Health has an extensive glossary on its website that her student interns update every year.

Ms. Mitchell remarked that the Advocacy Committee had wanted to know if the new Medi-Cal will offer the same scope services of mental health services as Full-Scope Medi-Cal. Ms. Abbott replied that California has to establish its Essential Health Benefit and its Medi-Cal benefit, as well as what will be available under Medi-Cal that is now available under county mental health.

Ms. Abbott continued that the committee is concerned about homeless people who are seriously mentally ill and not currently receiving SSI, but need some level of services.

She suggested that if we cannot get everything that's in the Rehab Option, the Advocacy Committee should prioritize essential services.

## **7. Continue Committee Reports**

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

Committee Co-Chair Pat Bennett reported that the committee welcomed four new members yesterday.

At yesterday's meeting the committee approved its charter, and then heard Michael Ritter's presentation on External Quality Review Organization (EQRO) data. The committee had wanted to understand the availability of data they could use in creating products that could be useful to different stakeholder groups throughout California, particularly local advisory boards.

The committee had been joined by members of the California Association of Local Mental Health Boards (CALMHB) Board, and hoped for this to happen at all of its committee meetings. The committee has been charged with working with advisory boards, receiving information from them and passing it on and reporting it to the state. In the past the committee had developed a workbook to help facilitate that process.

Ms. Susan Wilson explained that several years ago, the Planning Council had partnered with the CALMHB Board and the California Institute for Mental Health (CiMH). They had produced a workbook that addressed the issue of penetration in local counties. Its intent was for the counties to produce a report for the Planning Council about the status of their programs.

The subcommittee (Ms. Dickerson, Ms. S. Wilson, Ms. Nepomuceno, Ms. Eargle, Ms. Hart, Ms. Bennett, and Ms. Flores) was now starting from scratch in redoing the workbook. Ms. Wilson thanked Cary Martin and Herman DeBose from the CALMHB Board for their input. Ms. Wilson felt that this is an important project that the Planning Council can use to build strength in the CALMHB Board and in the local mental health boards.

Ms. Bennett emphasized that yesterday's PowerPoint presentation would be valuable for everyone on the Planning Council who is data-phobic or data-hungry. The data, which is basically county-level, is accessible on the web. Ms. Bennett explained the kinds of data to be found; it is not used as much as it might be.

The committee had also discussed other topics and issues for which the members had energy and passion. One such topic was the impact and effect of trauma upon children, including what is happening around the state and in mental health services. Another issue of interest was what is happening with school-based mental health services, especially with last year's legislative changes.

The next big effort for the CSI Committee will be to produce a committee work plan for the year. They hope to have a full Council work plan to offer for input as well.

Ms. Shaw noted that the EQRO is Medi-Cal related data only. Ms. S. Wilson added that EQRO only looks at some of the services.

Ms. Bennett said that with realignment of mental health services, there is no overarching state entity that reviews county plans for MHSA dollars. Most local plans will soon be due for updates. County Boards of Supervisors will be the ones to approve such plans; they will look to their local advisory boards for input. Part of the committee interest in collaboration with the CALMHB/C and in service to the local advisory boards anticipates this larger role for them.

### **Advocacy Committee**

Committee Co-Chair Gail Nickerson reported that the committee had expanded to include the work of the Legislative and Regulatory Committee (now disbanded). They had come up with a list of activities to focus on, the top three of which were:

- Hiring of peer counselors: many people with issues in the past are now ready to be support workers but have crimes on their records. The Advocacy Committee is looking at how to adopt and support the CASRA position on background checks. Ms. Nickerson distributed a letter for the Planning Council members to review.
- An initiative on violence and the perceived link to mental illness. The committee has drafted a letter to the Governor and the President which Ms. Nickerson also distributed for review.
- Many of those with mental problems also have dental problems, which increases their stress and difficulties.

Ms. Mitchell explained that the second draft letter emphasizes that mental illness is not necessarily a determinant of violence – that the media links between mental illness and violence are greatly overblown. The letter also points out the decrease in federal funding because of the lower level of federal/Medi-Cal match. The letter addresses state funding as well, citing effective California models such as full service partnerships.

**Motion:** The support and acceptance of the Advocacy Committee’s letter addressing violence and the perceived link to mental illness was moved by Pat Bennett, seconded by Adrienne Cedro-Hament.

Ms. Abbott felt that Richard Van Horn’s statement that violence is a public health issue and should be treated as such, was the best comment she had heard after the Newtown murders. She thought the Planning Council should lead with that point.

Mr. Wilson felt that the problem has to do with the public not being well-informed about those with mental challenges.

Mr. Shwe did not feel comfortable approving the letter without reading it in its full entirety.

Ms. Eargle agreed that the Planning Council members need more time to look at the letter. In addition, it is a long letter which may make people inclined to set it aside. She suggested shortening it and making use of bullet points.

Ms. Vanderhurst supported sending the letter, but felt hesitant to call out the schools as having a major gap.

Ms. Mueller commented that [healthypeople.gov](http://healthypeople.gov) is a website for Healthy People 2020, the public health initiatives that are expected to be implemented at state and local levels. It is a framework for thinking about what programs get funding and the focus different programs have.

Ms. Mitchell responded to concern about mentioning violence and mental illness in the same letter. For the past 20 years, as she has given public presentations, that link consistently comes up in questions from the audience. News reports convey the same link. Ms. Mitchell felt that the Planning Council had to answer this to some extent. She recommended the Treatment Advocacy Coalition, which is pushing more involuntary treatment by citing incidences of violence by people with mental illness.

Ms. Eargle stated that the MacArthur Foundation has done a lot of research with violence. She concurred that schizophrenia can result in a higher rate of violence, but only for certain types and symptoms. There is a lot of information out there but much of it is conflicting; the details of the studies must be considered.

Ms. Lewis shared personal knowledge of a link, in the double murder/suicide of her own family members. She understood the issue of stigma which the Planning Council did not want to perpetuate. The Planning Council must stand up and say that in some instances, but not all, the outcome can be violence if there is not enough intervention and prevention at every level.

She added that many well-meaning letters are sent containing information that people already know. Ms Lewis would like to see a descriptive subject line that carries the weight of the letter, just in case the letter's contents are not read.

Ms. Bennett did not feel that the Planning Council members were disagreeing substantially. It is incumbent on the Planning Council to make a statement. Commenting on the committee process, she said that we must walk a fine line between being responsible and allowing members to read the full letter to support it, and allowing the committee to do their work so that the rest of the Planning Council is not micromanaging. She encouraged everyone to think about that balance.

Ms. Mitchell stated that the Planning Council had agreed that committees could send out letters if they were consistent with our legislative platform. However, this particular issue is more complicated.

The Planning Council members discussed what to do. Dr. Nelson remarked that the letter dealt with two issues: the link between violence and mental illness, and the need for more services and funding for mental health treatment. The problem is that the two messages are coming into conflict with each other.

Ms. Mitchell noted that the committee intends to write one-page position papers for the Planning Council to endorse.

(Ms. Bennett withdrew the previous motion; Ms. Cedro-Hament withdrew her second to the motion.)

At the request of Executive Officer Adcock, the committee established that final approval of the letter would be by leadership rather than Executive Committee.

**Motion:** That the Advocacy Committee revise the letter to lead with the concept that violence is a public health problem; that the letter be shortened; that the committee attempt to disengage from the link coming across; and that the committee be authorized for leadership to send the letter, was moved by Barbara Mitchell, seconded by Pat Bennett. Motion passed with one vote of nay.

Chair Ryan requested suggestions on how to speed up the approval process for future letters. Ms. Abbott noted that this subject is particularly complex; the letter is not typical. Ms. Bennett proposed circulating letters ahead of time.

Ms. Mitchell resumed the report on the Advocacy Committee meeting.

The committee addressed the issue that it is nearly impossible to have consumers hired to work in licensed programs because of the extreme background checks they must undergo. Many consumers have criminal records due to past substance abuse, untreated mental illness, and so on. If people have misdemeanors as minor as loitering and littering, they must go through an extensive background check.

CASRA represents most of the agencies in California that have licensed facilities. Mr. Robinson had drafted a statement from CASRA suggesting two alternatives:

- Allow social rehabilitation facilities to hire staff pending the criminal background check (as it used to be).
- Use the system that drug and alcohol programs have: there are no background checks. The employer does the background check by going through the Department of Justice. The employer receives the criminal record statement and decides whether to hire the individual or not.

A letter from the Planning Council would let CASRA know that we support their position.

Mr. Riel expressed concern that the state should have some legal protection for when it sends consumers to CASRA organizations. The discussion continued with Mr. Ryan requesting Mr. Robinson to bring committee concerns back to CASRA, and Mr. Cunningham to bring committee concerns back to the California Department of Alcohol and Drug Programs.

Ms. Mitchell reported that the committee intended to write a letter to the Governor requesting that Medi-Cal optional dental benefits be reinstated after being cut in 2009. Federal mandates conflict with what the state has sent out. The committee feels that reinstatement of dental services under Medi-Cal are essential to people's mental health.

Chair Ryan addressed the Planning Council process; the committee was asking approval to send a letter regarding this issue. Ms. Mitchell stated that the committee was not responding to a legislative item; they were asking that this reinstatement be part of the Governor's Budget.

Ms. Shaw felt that such a letter should come from the entire Council. Ms. Vanderhurst agreed that anything the Planning Council can do to improve the lives of the people we

deal with should be done, in our role as advocates. She also suggested that it would be helpful to share position letters with local mental health boards and commissions.

The members discussed the link of dental health with mental health and also employment opportunities.

Mr. Cunningham pointed out that in some cases, the appropriate advocacy is working within departments with the person responsible for that program – here, representatives of the Department of Health Care Services who can become more aware and knowledgeable on the issue of mental health related to services such as dental care.

**Motion:** That the Planning Council take a position advocating restoration of DentalCal benefits in California, was moved by the Advocacy Committee. Motion passed with one abstention.

## **8. Council Member Open Discussion**

Chair Ryan stated that this a new agenda item that gives Planning Council members an opportunity to discuss any important issues relating to our overall vision and mission. Members had responded with three issues: leadership, the stakeholder process, and DHS.

### **Leadership**

Ms. Lee felt that the term “leadership,” constantly used at the Planning Council, detracted from members who are not “leaders” and are reluctant to come forth. Ms. Nickerson suggested the term “Council Officers.”

Ms. Bennett suggested the term “Steering Committee.” She felt that the definition of “leadership” is critical to government, non-profits, and the world we live in. Her concern is how we behave as leaders, as well as how we are trained as leaders – critical to being an effective Council.

Ms. Hart liked the idea of a conversation about leadership. She wondered if anyone has felt intimidated by the term “leadership,” and noted that the term does include Executive Officer Adcock.

Ms. Lee commented that when consumers have offered suggestions, there is no response from the rest of the Planning Council. This limits the consumers’ productivity.

Ms. Hart commented that this happens to everyone in the room: not getting an affirmation back. She felt that the issue is larger than just consumers – we should look at our responses to everyone.

Chair Ryan directed the Council members to email Executive Officer Adcock with suggestions for other terms.

### **Stakeholder Process**

Ms. Bennett mentioned that the Mental Health Oversight and Accountability Committee (MHSOAC) has come up with guidelines; Mental Health America of California is also drafting position papers. Because the Planning Council is consumer-driven and family-driven, it needs to weigh in on this issue.

Executive Officer Adcock referred to a handout in the folders from the California Stakeholder Process Coalition, which she participates in. Over the last several months, an Ad Hoc Committee within the Coalition has been working to develop this document. It builds on existing state statute and regulations that already put forth requirements about stakeholder engagement and information-sharing that the county boards must follow. It then defines meaningful stakeholder involvement.

The Coalition is meeting with Vanessa Baird, DHCS Deputy Director, to submit the document as proposed language to include in the counties' performance contracts. The Coalition welcomes and invites the Planning Council to submit additional comments and input on this draft language. The document is an effort to derive consensus across the mental health constituency for basic standards and expectations to which counties can be held.

Executive Officer Adcock saw this as the first step down a road that will take years. We are interested in establishing a baseline for meaningful stakeholder engagement; we also need to insert some regulations and possibly expand the state statute (a whole other lengthy process). This issue is at the forefront of many people's minds. It is a cornerstone of the MHSAs and our transformation of the system.

Mr. Wilson commented on the importance of team effort. If the organizations, the county, and the state pull together as a team rather than as individual entities, they will probably do much better.

### **Substance Abuse and Mental Health Services Administration (SAMHSA)**

Chair Ryan stated that SAMHSA, a funding source for the Planning Council's block grant, sent an invitation to all the state planning councils to offer technical assistance to those who have a motivation to become behavioral health planning councils. The requirement for the Planning Council is to get approval from the DHCS. Ms. Vanessa Baird had responded that this was not part of the DHCS plan, and not to proceed.

On Monday the Planning Council leadership will have a conference call with a SAMHSA representative to get a better understanding of what is happening nationally. Chair Ryan's sense was that DHCS feels an oversight responsibility on the Planning Council, rather than the Planning Council having oversight responsibility on mental health services in the state. DHCS does not seem used to advisory groups and consumer groups.

Chair Ryan felt that at some point this issue may come to a head.

Executive Officer Adcock stated that without the endorsement of the state agency, i.e., DHS, the Planning Council was not eligible to apply for the funding.

Mr. Wilson stated that it is a proven fact that county entities need to work together as a team.

Ms. Lee asked about the DHCS refusal; Chair Ryan quoted from their response: the Planning Council should not be moving in this direction unless DHCS has asked for it.

Dr. Nelson noted that the Planning Council may not have to limit itself to their response. As an advisory council, we have it within our purview to look into any and all issues that are impacting mental health care, including the provision of services.

Ms. Bennett referenced the reorganization of the state Mental Health Department, and the Planning Council's concern then over lack of understanding about its mandate according to statute. She felt that the Planning Council has some education of DHCS to do.

Ms. S. Wilson proposed taking advantage of this period of time to develop a plan for what the Planning Council really wants to do and what it might look like.

Ms. Nickerson commented that when they attended the SAMHSA block grant meeting in Baltimore, it was very clear from the federal perspective that this was going to be combined.

Mr. Cunningham stated that there is a very different relationship within SAMHSA between the mental health services block grant and the alcohol and drug block grant. In the former, the Planning Council has a clear responsibility in terms of the block grant. For the latter, there is no counterpart. That alone sets up a very different dynamic.

He continued that the grant should go to states that have committed to move in the direction of having behavioral health planning council. The first point of dialogue should be the stakeholders who represent the alcohol and drug community.

Chair Ryan noted that the SAMHSA block grant for alcohol and drug was five times the size of the mental health block grant.

Mr. Cunningham stated that the alcohol/drug and mental health programs in 50 of the 58 counties operate under a combined administrative structure, although they have separate systems of care and operate quasi-independently from each other.

Ms. Cedro-Hament mentioned parity between mental health and substance abuse. Los Angeles County has done its own work from the bottom up with joint presentations and joint conferences.

Chair Ryan concurred with Mr. Cunningham that there is concern in the alcohol/drug community with being swallowed up and forgotten. He added that under California state law, the Planning Council is mandated "...to conduct public hearings on the state mental health plan, the substance abuse and mental health services administrative block grant, and other topics as needed." Thus there is a basis for the Planning Council to hold a public hearing on the block grant for substance abuse.

Ms. Bennett referenced the issue of how the Planning Council is looked upon and how we communicate with DHCS. We need a strategy as a council.

## **9. California Hospital Association's Effort to Examine and Modify the LPS "5150" Act**

Ms. Sheree Kruckenberg, Vice President of Behavioral Health, California Hospital Association (CHA), gave a presentation. She has been charged with looking at the challenges that hospital emergency departments are facing with the explosion of the number of people either self-presenting or being brought by others to emergency departments. Below are highlights of the presentation.

- In the last five years, the number of people with a mental health diagnosis has increased by 76% in emergency departments. This is causing multiple unintended consequences to those individuals, other patients, and hospital staff.
- In the process of proposing modification to the Lanterman-Petris-Short (LPS) Act, the CHA:
  - Is not going to be changing the current criteria of what constitutes the authority for people to detain someone involuntarily.
  - Is not addressing child-adolescent issues.
  - Is not proposing to change any of the current court processes.
  - Intends to reduce the wait times in emergency departments for people with mental illness.
  - Intends to reduce the non-emergent mental health care visits to emergency departments.
  - Intends to improve the safety level in emergency departments for all patients and staff.
  - Wants to improve access to the least restrictive level of care for those with a mental illness.
  - Wants to improve the coordination of services between county mental health plans, law enforcement, and providers of mental health treatment.
  - Wants to standardize who can write a hold, who can lift a hold, and the timeframes for when the hold is in existence.
  - Wants to improve uniform application of the law from county to county.
- Ms. Kruckenberg summarized the history of mental health treatment in California since the LPS Act was written 45 years ago. The delivery system then was very different – most involuntary treatment was provided in state hospitals.
- At present, in California’s five state hospitals there are about 6,000 beds, 2,000 of which are committed for those with an acute psychiatric need. This is down from 25,000 beds in the early 1970s.
- The application of the LPS is inconsistent, varying by county, city, and even hospitals within the same city.
- California hospitals are not required to have emergency departments. 70 hospital emergency departments have closed between 2000-2010.
- California has 127 hospitals that provide inpatient psychiatric services to both the voluntary and the involuntary population.
- 25 of the 58 counties have no inpatient psychiatric services. The remaining 33 counties are absorbing individuals from other counties into their communities. This

results in cross-county issues in management of the cases, as well as support structures.

- Most emergency departments do not and were never envisioned to provide emergency psychiatric treatment – only physical health treatment.
- 25 years ago the federal government passed the Emergency Medical Treatment and Active Labor Act (EMTALA). There are conflicts between the California state involuntary commitment laws and the EMTALA laws.
- Emergency departments across the nation are now being used as primary care sites for everyone. California has 14 million emergency department visits per year.
- The CHA believes in the original intent of the LPS Act:
  - To end inappropriate indefinite involuntary commitments.
  - To provide prompt evaluation and treatment, to guarantee and protect public safety, to safeguard individuals' rights with a judicial review, and to protect people with mental illness from criminal acts.
  - To provide individualized treatment, supervision, and placement; to encourage the full use of existing agencies, professionals, personnel, and public funds; and to prevent the duplication of services and unnecessary expenditures.
- The CHA will be adding some language that addresses the statewide applicability of the law.
- To qualify for involuntary commitment, an individual must be suicidal, homicidal, or gravely disabled due to mental illness. However, there is much variation in how this is applied. For suicidal and homicidal, the individual must have a means and a motive. Dementia and Alzheimer's are not considered mental illness.
- Ms. Kruckenberg summarized the CHA's involvement with the LPS rewrite. In 2012, the LPS Taskforce released a report with 14 recommendations. The CHA Board of Trustees reviewed them and narrowed them down to four:
  1. Combine competency hearings.
  2. Standardize the form for developing and collecting a patient's mental illness history.
  3. Standardize the list of people who can generate, release, or continue holds.
  4. Insure uniformity in the application of the LPS Act in California.
- The CHA is now looking at the last two recommendations.
- Ms. Kruckenberg has hired an attorney, Steve Lipton, to do a legal review of the entire LPS law – all 400 sections.
- She and Mr. Lipton have hired a firm to do some data analysis. The firm has looked at the 14 million emergency department visits, as well as each encounter and each diagnosis for a five-year period. They will give the information county-by-county.

- A staff person is assessing how the LPS Act is currently applied in each county.
- The CHA intends to be active in this legislative session.
- The CHA is focusing on three parts of the law, all of which are pre-admission:
  1. The 5150: the statement that police officers can detain and transport someone that they believe meets the threshold for an involuntary detention.
  2. The 5151: the actual assessment done by someone trained to do psychiatric assessments, to determine if what the police thought they saw, is enough to take someone's civil rights away for a 72-hour period.
  3. The 5152: the decision that someone needs a pre-admission assessment prior to being placed in an inpatient involuntary psychiatric bed.

Ms. Cease asked about complete and uniform training for police officers in dealing with mentally ill people. Ms. Kruckenberg responded that the stigma for mental illness is probably even worse in emergency departments than in the police forces. She did not believe that mandatory training would ever happen for all law enforcement: it would be considered a mandate, and there is no funding for a mandate.

In the budget he signed last week, Governor Brown sent the 5150 oversight back to the DHCS. The CHA is celebrating this as a victory.

Other changes to the LPS that the CHA is seeking are:

- To add definitions to the Act, expanding the list from eight to about 30.
- To include some language in the Act, encouraging the counties to develop crisis services.
- The LPS designation needs to be clarified. It means counties identifying sites where detained individuals are supposed to be taken must have an assessment determining if the detention is legitimate.

Ms. Kruckenberg explained the materials in the packet.

### **Questions and Comments**

Ms. Cedro-Hament asked about Laura's Law. Ms. Kruckenberg responded that it is not being addressed in the proposed changes to the LPS Act. Ms. Lewis stated that L.A. County is doing a pilot program of Laura's Law.

Ms. Abbott observed that the Planning Council would be interested in seeing the actual language of the proposed changes – the devil is in the details. Ms. Kruckenberg agreed and said that when the CHA releases the language, it will be at least 50 pages long. It will include a rationale.

Dr. Nelson expressed concern with the issue of ensuring uniformity of implementation of the LPS Act. Among the counties and jurisdictions there is a lack of uniformity and quality of resources, resulting in wide variations in the application (or misapplication) of LPS rules and regulations. Ms. Kruckenberg agreed. In the proposal language, the CHA encourages small counties to work together and collaboratively use single resources.

Ms. Vanderhurst made the point that law enforcement may transport someone to an emergency department under a 5150, then based on community available resources preadmission, that person would not need to be detained.

Ms. Vanderhurst made the additional point that because of the impact on individuals seeking treatment in emergency departments for physical needs, hospitals are hesitant to hold someone for 23 hours. There is pressure to get the person out of the emergency department and to make a recommendation for hospitalization that may not be appropriate.

Ms. Mitchell suggested for CHA to take another look at the recommended figure of one hospital psychiatric bed for every 2,000 people: such a system would need to be financed very differently from the current system. Ms. Kruckenberg replied that this is not about increasing the number of inpatient psychiatric beds. CHA is committed to the recovery movement; they believe in voluntary treatment. Patients leave the hospital more quickly if they are there voluntarily – they embrace their care.

Ms. Kruckenberg added that she was using the E.F. Torrey study as the data source in the absence of a better one.

Ms. Shaw suggested that separating all the information about increasing inpatient hospital beds from the efforts to change LPS might be a good idea.

Ms. Mueller asked if there were stakeholder groups that were going to be opposed to this legislation. Ms. Kruckenberg responded that most people are initially opposed. Once they become educated and hear about how the LPS Act is bizarrely applied, they do want the law fixed. Ultimately hospitals and counties are going to like some of it and not like some of it.

Mr. Frank Topping, Sacramento County Mental Health Board, told about a respite partnership collaborative, with learning as the objective, in which private partners can successfully work with a government agency. It was begun by the Sierra Health Foundation and the Sacramento County Department of Behavioral Health Services under the Innovation Plan of the MHSA. He asked about any mentoring, scholarships for training, or support available for programs such as this. Ms. Kruckenberg replied that the first person to approach in the Sacramento area would be Scott Seamons.

#### **10. Forum: Re: CMHPC & MHSOAC Areas of Responsibility**

Chair Ryan stated that this agenda item was a continuation of the discussion begun at the previous meeting. He was going to share current thoughts on the issue of overlaps between the Planning Council and the OAC, explaining their requirements, budget, and other issues.

Chair Ryan introduced Sherri Gauger, OAC Executive Director; and Filomena Yeroshek, OAC Legal Counsel.

Executive Officer Adcock gave a presentation comparing the two organizations. She compared:

- Federal mandates

- State mandates
- Composition of members and staff
- Budgets
- Missions
- California Welfare and Institution Code (WIC) Sections that apply to the organizations

Chair Ryan related the events of the previous OAC meeting which he had attended. During the meeting, Rusty Selix, the primary author of Proposition 63, said that he had originally envisioned for the OAC to be responsible for California's total mental health system. He now felt that to be a mistake; it was not put clearly.

Mr. Selix requested Chair Ryan and OAC Chair Van Horn to take six months to work out the roles and responsibilities between the two organizations. If that didn't work, he would go to Senator Steinberg and have him introduce legislation ensuring that the OAC was responsible for everything.

Chair Ryan continued that the disparity in budgets between the two organization results in a playing field that is not level. Yet there is duplication and overlap in duties – for example, performance outcome development. Chair Ryan had recommended possibly going before Senator Steinberg to recommend that the two organizations be combined.

A strong point for the Planning Council was its integration of all the state partners.

The OAC is independent of the DHCS, while the Planning Council is dependent upon DHCS and is effectively low on their feeding chain.

## **11. Council Discussion of CMHPC Role**

Ms. Cedro-Hament commented that the Planning Council had been told that their role was to continue to look at the entire mental health system, while the OAC would oversee the Prop 63 money.

Chair Ryan remarked upon the risk factor that the OAC could wind up at DHCS with the Planning Council.

Ms. Lee was astonished at the discrepancy in the two budgets.

Ms. Bennett thought that the conversation should turn to how we can collaborate and leverage our unique positions; philosophically we are aligned.

Ms. Shaw commented that in the early days of Prop 63, the thought for the OAC was that in order to do true oversight, commissioners should not come from the field of mental health.

Mr. Shwe suggested for the Planning Council to work more closely with the OAC – they are separate organizations with different missions.

Ms. Shaw commented that several years ago, she and former Executive Director Ann Arneill-Py had met with members of the OAC to look at overlapping responsibilities in the areas of evaluations and performance outcomes.

Ms. Nickerson remembered attending such a meeting. She noted that the Planning Council does advocacy while the OAC does not. More collaboration is certainly desirable.

Dr. Nelson asked for clarification on the pressure to resolve differences between the two organizations. Chair Ryan replied that with Realignment, a time may come in the future when people will stop and point out the overlap.

Ms. Shaw recalled the California Council on Mental Health, which was sunset before Realignment in 1991. The lawmakers had added into state statute all of the responsibilities of that organization for the new Planning Council, which had been established to get the federal dollars.

Ms. Abbott stated that the two organizations are aligned in terms of purposes, so there is nothing to be afraid of in the concept of collaboration. The Planning Council's CSI Committee probably could link into the OAC's evaluation effort; the Planning Council could contribute the MHB work.

Mr. Wilson emphasized the idea of working as a team for anything to be successful.

Ms. Mitchell gave a historical perspective. Much of the language in the MHSA program was lifted from the Planning Council's California Master Plan – particularly regarding housing: a selling point for the public was getting homeless mentally ill people off the streets. The additions of Prevention and Early Intervention (PEI) and Workforce Education and Training (WET) came from other constituency groups.

Executive Director Gauger stated that there had been no formal discussion at the OAC on the overlap topic. She and other staff see many parallel responsibilities, but not a lot of overlap. There is overlap in the evaluation arena, and as a result of AB 1467, a need for consulting and collaborating in terms of performance outcomes (also with CMHDA and DHCS).

She continued that up until this point, the focus of the OAC has been the MHSA. There is no discussion underway to go beyond it (MediCal, Prop 63, etc.) The Master Plan that the OAC will introduce at their January meeting will lay out priorities for the next 3-5 years. Some of its activities are natural opportunities to work with the Planning Council.

Ms. Gauger stated that the OAC has \$875,000 per year for evaluation. However, \$1.2 billion goes out every year to support MHSA programs – so about 0.1% is being invested at the state level in Prop 63 evaluation. If the OAC tries to follow its Master Plan, the \$875,000 will be grossly insufficient.

Ms. Hart felt that the Planning Council should be as inclusive as possible with all of the people involved. The two organizations can have a profitable coexistence that will benefit the people whom they intend to serve and help.

Ms. Bennett said that part of the charge of the CSI Committee is revamping the "Workbook" to be used by advisory boards. It would be useful to this effort to have input from a member of the OAC's Evaluation Committee.

Ms. Abbott asked if health care reform is assigned to a committee at OAC. Executive Director Gauger replied that it is assigned to the Financial Oversight Committee.

Executive Director Gauger added that she would look into having a staff person participate in the CSI Committee's efforts.

OAC Staff Counsel Filomena Yeroshek noted that during her four years on the OAC, she has seen collaboration between the two organizations when the OAC does RFPs for contracts, during scoring for the recent evaluation, and so on. She encouraged Planning Council members to continue serving on the OAC's committees to offer their opinions and views.

Mr. Cunningham suggested that it might make sense for the leadership of the two organizations to have a conversation to set an overall framework, so that messaging is clear. This would be in addition to work on the committee level.

Chair Ryan summarized the next steps:

- Planning Council leadership would see about informal meetings with the OAC.
- The Chairs of the obvious two committees would talk to their counterparts at the OAC.
- The Planning Council would see about staff attending committee meetings of the OAC.

Ms. Hart pointed out that OAC meetings are available by conference call. Executive Director Gauger reiterated that all meetings are open to Council members as well as the public.

## **12. Public Comment**

There was no public comment.

## **13. New Business**

Ms. Abbott referred to the concern that children's issues were not going to be addressed with the Planning Council's new structure. Perhaps people could meet on Thursdays at noon to use the Issue Statement. Then they could strategize about how to funnel those issues into the committees.

Chair Black recessed the meeting at 4:26 p.m.

## **Friday, January 19, 2013**

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

In the absence of Chair Ryan, Chair-Elect Monica Wilson brought the meeting to order at 8:39 a.m. She welcomed the Planning Council and audience members; everyone introduced themselves.

### **2. Opening Remarks**

Chair-Elect Wilson introduced John Sturm, Chairman of the San Diego County Mental Health Board.

Mr. Sturm expressed pride in San Diego County's mental health programs. He said that San Diegans think outside the box, coming up with ideas that haven't been done before that have proven outcomes. Following are three examples.

- The new In-Home Outreach Program (IHOP) team was San Diego's response to Laura's Law, which the Board of Supervisors had chosen not to implement. The IHOP team is for people who refrain from seeking services.

The team has many peer specialists, and the success rate has been very high for severely mentally ill people who aren't getting the services they need. The team is available 24 hours a day. They reach out to everyone, including those who have not been incarcerated or hospitalized.

- Mr. Sturm has observed a serious lack of communication across California between law enforcement and some of the mental health boards. He spoke of a form that can be used by first responders: EMTs, police, anyone who would be coming in a crisis. It will give some information about what they may be dealing with. The information is given by clients and they can revoke it at any time.
- An ongoing suicide prevention campaign called Up To Us has wide media distribution. For every television ad the County Mental Health Board pays for, the television stations give a free ad. There is a component in the campaign for physicians to know what to look for in older people.

Mr. Sturm would like to see more communication go on between the various mental health boards. What works in San Diego may not work everywhere, but there are certainly some great ideas coming out of San Diego.

As a consumer, Mr. Sturm has used every service available in San Diego: AA, mental health, medical, MediCal, food stamps, housing, SSI. His voice is to share the real-life experiences he has had. For example, he has found that some programs look good on paper, but they don't look at why a person did not show up for a second appointment.

He closed by saying that in his youth he learned that secrets can kill. He wants to remember where he came from in order to serve the people he intends to reach.

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

Cary Martin, President of the California Association of Local Mental Health Boards (CALMHB), shared some thoughts with the Planning Council. His first objective was to call attention the point in time years ago where the first half was happening: the California Department of Mental Hygiene was history. The second half was when, hostage to the Governor's promise to get the state "out of the business of mental hygiene," the California Department of Mental Hygiene was on the chopping block.

After meeting with Mr. Martin, Senator Milton Marks rose from his sick bed, returned to Sacramento, and changed his vote on the override of the Governor's veto. This saved the last half of Mental Hygiene.

California has since been the national and worldwide bellwether for mental health care and service. We owe far more to Senator Marks than Mr. Martin can describe. Mr. Martin suggested commemorating Senator Marks' heroism and legacy as a humanitarian for all Californians, with special recognition of his sacrifice for all who now have an interest in behavioral health.

Mr. Martin moved to a more recent time: one of stress for the corporate structure devised by the California boards and commissions of the 58 counties to support their legislatively mandated mental health services and responsibilities – that is, the CALMHB board. Since its inception it has borne the brunt of ill concern and abject neglect.

A few weeks ago, the CALMHB Board was devastated to hear that OAC Chair Richard Van Horn would not be meeting with them as scheduled. The Board was relieved to hear from OAC Executive Director Gauger that she would carry the CALMHB Board's message to the OAC, and relieved to hear that the CALMHB Board's contract would be renewed this year.

Mr. Martin noted that during the Planning Council's latest CSI Committee meeting, someone raised the subject of prevention. He said that a collaborative effort of CALMHB and the Planning Council to eradicate mental illness would be the first step toward realizing that dream.

#### **Questions and Comments**

Ms. Cedro-Hament agreed with Mr. Martin in thinking in the light of collaboration. She looked forward to the Planning Council having closer ties with the CALMHB Board.

Ms. S. Wilson, on behalf of "CSI Sacramento," thanked Mr. Martin and Mr. DeBose for helping the committee with the data they needed to proceed. They are looking forward to the workbook project.

#### **4. Report from DHCS**

Rollin Ives, Special Advisor to the Director and Deputy on Mental Health and Substance Use Disorder Services, stated that the Planning Council plays a very important role in California. Its advocacy for effective and quality mental health programs is needed now more than ever, as the state plays an increasingly important role in oversight, monitoring, and accountability, given Realignment and the shifting of roles and responsibilities.

Mr. Ives gave an overview of seven key DHCS issues.

1. The new DHCS organizational structure. DHCS has areas or "divisions." Vanessa Baird is deputy of the new Mental Health and Substance Use Disorders area. Under that area are two divisions: Mental Health Services and Drug/MediCal Services.
  - a. Mental Health Services has three branches: Program Oversight and Compliance, Program Policy and Quality Assurance, and Financial Management and Outcomes Reporting.

- b. Drug/MediCal has a field branch and a fiscal management's branch.
2. Health Care Reform. Much of the work of DHCS is focused on defining assumptions, benefit package options, and delivery systems for the Medicaid expansion population as part of the Affordable Care Act. The federal government 1115 Waiver requires the state to submit a service plan to the Centers for Medicare and Medicaid Services (CMS) to outline how DCHS intends to meet the requirements of the Affordable Care Act, for the behavioral health benefit for this expansion population. It is due on April 1.
3. The Governor's Budget. One of the key elements in the Governor's proposed budget is a state-based option and a county-based option.
  - a. The state-based option is the current Medicaid program for the expansion population.
  - b. The county-based option, which has many more question marks around it, involves the counties running the new benefit program.
4. The Healthy Families transition. Now that Healthy Families is not functioning and the children have been transferred to Managed Care, DHCS plays an important oversight/quality assurance role.
5. The Duals Demonstration, a three-year program that promotes coordinated and integrated health care delivery. Focused on those who are dually eligible for MediCal and Medicare, it is being implemented in eight counties.
6. The Business Plan initiative between the CiMH and the Alcohol and Drug Policy to provide guidance to DHCS and the counties going forward with key priorities and activities. This is not just the responsibility of DHCS – in Realignment, the counties are even more critical as business partners. There have been a series of stakeholder meetings since August that identified core areas for the document.
7. Key DHCS activities in 2013.
  - Helping behavioral health partners, other state agencies, stakeholders, and the Legislature to feel a sense of connection and confidence with the new organizational structure at the state level.
  - Working closely with CMS on existing programs and new programs, particularly health care reform. DHCS is specifically working on developing the new Behavioral Health Benefit as part of the Affordable Care Act.
  - Working closely with the OAC around roles and responsibilities related to Prop 63 – administrative roles, fiscal oversight, etc.
  - Preparing for the transfer of the remaining components of ADP, as well as a proposed shift of mental health licensing from the Department of Social Services back to the DHCS.
  - A newer area is that the Managed Care Delivery System is continuing to assume a growing role in the delivery integration of mental health and substance use

services. DHCS needs to ensure that its Mental Health and Substance Use area is squarely in the middle of developing and monitoring quality assurance strategies for managed care plan oversight and accountability related to behavioral health.

### **Questions and Comments**

Ms. Abbott commented that the Planning Council has a Health Care Reform Committee, and has participated in the calls for the Dual Eligible Demonstration. The Planning Council has submitted a letter making two points: people in the mental health system need to get better health care services, and this was not clearly articulated in the MOU; and regarding the data sharing workgroup, the Planning Council could offer consumer points of view.

Ms. Abbott continued that when DHCS gets to the Health Care Reform service plan and benefits package, it is very complex. The Planning Council will need some help in understanding it. A phone call to the Health Care Reform Committee would be much appreciated.

Ms. Hunter commented that she hadn't understood some of the acronyms that Mr. Ives used.

Ms. Cedro-Hament spoke regarding two issues that Mr. Ives had not mentioned: the Planning Council's role with the block grant; and ensuring that cultural competency is really there in the block grant and seeing how it is implemented.

### **5. Report from CMHDA**

Jaye Vanderhurst, California Mental Health Directors Association, stated that the CMHDA is the membership to which the County Mental Health Directors belong. The CMHDA advocates for the positions from the county, and works fairly closely with state, federal, and other health care-affiliated agencies. Ms. Vanderhurst reported on issues CMHDA is working on.

- The priority is the state budget. Mr. Ives had talked about the two exclusive choices that will be available: the state choice and the county choice. CMHDA is working closely with the California State Association of Counties (CSAC) to make sure that whichever option happens is clearly understood by the counties.
- CMHDA is working on the issue that counties hold state hospital bed contracts. CMHDA is working actively with state hospitals as well as the California Mental Health Services Authority (CalMHSA) to come up with the best configuration. The proposed budget for 2013-14 includes an increase of \$2.5 million in county reimbursements for the purchases of LPS beds. This is in addition to the \$20 million increase to counties included in the last budget.
- CMHDA is working on issues related to the 2011 realignment with the behavioral health sub-account – particularly monitoring the MediCal specialty Early Periodic Screening Diagnosis and Treatment (EPSDT) for children, and Drug MediCal.
- CMHDA is working on the County Alcohol and Drug Program Administrators Association of California (CADPAC), the parallel association to the CMHDA.

- CMHDA is monitoring AB 109. The Planning Council has spoken in the past about wanting to make sure that there are mental health and substance use disorder services that are part of those packages.
- Proposition 30 has passed, providing an additional revenue source for the state to offset the cost of the realignment for the state General Fund, and also providing constitutional protections against future cost shifts to counties for the realignment programs. CMHDA is working with CSAC in analyzing how to operationalize these protections.
- CMHDA is actively involved in health care reform as described by Mr. Ives. CMHDA is also paying attention to parity and how it will be blended into the benefits for individuals.
- Regarding the President's plan to protect our children and communities by reducing gun violence – CMHDA is very involved in being able to provide consultation and to address the need to increase both mental health services and funding to children and young adults.
- In the spirit of sharing information, Ms. Vanderhurst reported from the standpoint of a small county that they are greatly benefitting from the work of the larger counties in the CalMHSA statewide Prevention and Early Intervention programs.

### **Questions and Comments**

Ms. Bennett asked about the Napa County residential program. Ms. Vanderhurst explained that it will be run by Probation, and it will probably be managed by an outside provider as the service provider.

Ms. Bennett asked if there is a place to get information about what percentage of money allocated to the counties for AB 109 has gone to the sheriff, new jail construction, or probation services. Ms. Vanderhurst suggested looking at the Chief Probation Officer associations.

Mr. Robinson said that the Californians United for a Responsible Budget (CURB) would have the most comprehensive information on AB 109. Ms. Murphy added that the website [californiarealignment.org](http://californiarealignment.org) has copies of all the county plans. There is also a report by California Forward.

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

Sherri Gauger, Executive Director of the OAC, reported on the following.

- Commissioner appointments.
  - The Governor's Office has appointed Leanne Mullett as Family Member with a Child, and Dave Gordon as School District Superintendent.
  - Dr. Larry Poaster was reappointed.
  - The Speaker has appointed Assemblywoman Bonnie Lowenthal to replace Mary Hayashi.

- Contracts.
  - The Commission approved the staff recommendation to award the client contracts to Peers Envisioning and Engaging in Recovery Services (PEERS). PEERS will subcontract with another organization to strengthen the breadth of their ability to provide services statewide.
  - The Community Planning Process Evaluation contract was awarded (again, with help from Planning Council staff) to Resource Developments Associates.
  - The OAC is going to require the contract holders to work together. One of their deliverables is to design a method to query stakeholders about the local community planning process.
  - Staff is reviewing contracts for compliance, for deliverables that are coming in from contractors. If they comply, they will be taken before the Commission for approval.
    - One such contract is from Sacramento State for the Full-Service Partnership Data Collection System.
    - Another is from UCLA and subcontractor Claris Research. They have submitted a report that describes the impact of the MHSA on client outcomes.
    - In the OAC's first attempt to evaluate Early Intervention Programs, UCLA and Claris Research have submitted a preliminary plan to identify a cohesive set of three Early Intervention clusters of programs and to evaluate their impact.
    - Contractors at UC Davis have submitted deliverables pertaining to their project on reducing disparities in access to care.
    - Dr. Jim Meisel has submitted an evaluation master plan for the OAC to prioritize its evaluation efforts for the next five years.
- Executive Director Gauger distributed an eight-page article done in the *Sacramento News & Review*, with stories from people in five area counties who have received Prop 63 services. The article tells how other people in those counties can access those services.
- The OAC will bring up the Prop 63 website by the end of February. Although maintained by the Commission, it will be dedicated solely to Prop 63. Other entities will be able to post on it.
- The weekend radio show, Free Your Mind, continues.

### **Questions and Discussion**

Ms. Cedro-Hament asked for an update on reducing disparities contracts. Ms. Gauger explained the strategic planning workgroups contract and the UC Davis contract.

Ms. Mueller asked about recruitment into training programs funded by Prop 63. Ms. Gauger responded that in the Evaluation Master Plan, the Workforce Education Training

and Evaluation is listed as a priority. It is the beginning of the state and the counties being able to look at ways they can build on each other's evaluation efforts and enhance resources.

#### **7. Discussion Re: Joint CMHDA and CADPAAC Health Care Reform Principles**

Ms. Adcock stated that the Planning Council and the County Alcohol and Drug Program Administrators Association of California (CADPAAC) have developed some joint principles to guide the implementation of health care reform. It was requested that the Planning Council look at the principles for changes, additions, and/or endorsement.

Ms. Bennett suggested that because the Health Care Committee has not discussed the document, and because their representatives were not present, the vote might be postponed.

Ms. Shaw commented that earlier, the Planning Council had shown concern that in the MediCal expansion, they might lose their focus on the rehabilitation option. The document could use stronger language on this issue.

Ms. Vanderhurst spoke about the collaborative effort between the two organizations in this establishment of core principles. The key point for the Planning Council was the evidence of organizations staying united and working closely with state agencies involved in this effort.

**Motion:** The postponement of approval of the CMHDA-CADPAAC Health Care Reform Principles to the next meeting was moved by Daphne Shaw, seconded by Patricia Bennett. Motion passed with one abstention.

#### **8. Public Comment**

Larry Gasco, Chairman of the Los Angeles County Mental Health Commission, spoke about revisions to the Lanterman-Petris-Short Act as addressed earlier by the CHA. In Los Angeles they had convened a stakeholder group to review the recommendations. He provided Ms. Adcock with a copy of the review for the Planning Council members to read.

Carole Marasovic of the Berkeley Mental Health Commission and the CALMHB Board raised the issue of the importance of EQROs. She also distributed copies of an article from the *East Bay Express* on the failure of AB 109. In this time of diminished funding, all the money is being kept within Probation and not shared with the community partners.

Herman DeBose of the Los Angeles County Mental Health Commission commented on the absence of discussion on HIV/AIDS in the mental health community. Mr. Ives responded that now that they are part of DHCS, there is an office; he asked Mr. DeBose to bring the question to his attention.

George Fry of the Calaveras County Mental Health Commission was pleased with the election of Ms. Wilson as Chair and the appointments of Ms. Lewis, Mr. Robinson, and Ms. Flores to the Planning Council. He added that AB 109 is alive and well in Calaveras County.

Mr. Sturm stated that one of the programs that San Diego County financed was to help reimburse the county for CMS funds. They work on getting people who are on General Relief onto SSI. This has changed and stabilized many lives.

Mr. Topping commented as a private citizen on the budget hearings from the Community Corrections Partnership in Sacramento County. His supervisor had objected to the vote to overturn the budget. Mr. Topping would like to see the Planning Council advocate for getting control turned over to the Boards of Supervisors.

## **9. New Business**

Ms. Cedro-Hament asked about Laura's Law – NAMI members have been advocating for full implementation, but only two counties have implemented it. She asked why. Ms. Mitchell responded that last year, the Planning Council had voted against renewal and any extension of Laura's Law. It had passed anyway.

Ms. Mitchell continued that it is a highly controversial law. There are mixed views on its value, cost effectiveness, and efficacy as compared to other methods. She offered for the Advocacy Committee to take it up again. Senator Leland Yee has introduced a bill to allow use of MHSA funds for implementation of Laura's Law – but this is prohibited under MHSA provisions.

Ms. Bennett stated that if the full Planning Council was going to bring back the topic of Laura's Law, it would be useful for organizations on both sides who are fully knowledgeable to present the information.

Ms. Adcock requested direction from the Planning Council members if they agendaize Laura's Law for the next meeting: are we planning to educate, or to discuss our position again?

Ms. Lee commented that the writing of Laura's Law was not initially well done. She wanted to know why some counties were honoring it.

Ms. Mitchell noted that Nevada County had given an extensive presentation from both sides. If the Planning Council wanted to reopen its position, there needs to be a purpose.

The Planning Council members discussed the issue.

Ms. Adcock closed by stating that Nevada County (the originating county) is the only one that has followed the letter of the statute and implemented Laura's Law. Los Angeles County and San Diego have implemented similar programs. Ms. Adcock offered to put together a forum to educate the Planning Council (including the new members) and analyze the legislation; but it is a very difficult and contentious law.

## **10. ADJOURN**

Chair-Elect Wilson adjourned the meeting at 11:41 a.m.