AGENDA
CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL
June 20, 21, & 22, 2018
Sheraton Gateway Hotel
6101 West Century Boulevard
Los Angeles, CA 90045

Meeting Objectives:

1) Provide input to Los Angeles County re: legislation to expand definition of "gravely disabled"
2) Approve a 5th year budget for the Workforce Education and Training 5-Year Plan
3) Learn about Mental Health advocacy/collaboration in jails
4) Continue development of Cultural Humility/Awareness and Implicit Bias

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

Wednesday, June 20, 2018		**Room**
8:30 a.m.	Executive Committee	San Clemente
10:30 a.m.	Patients' Rights Committee	Santa Catalina
10:30 a.m.	Caucuses	
	Children/Youth	Salon 219
	Reducing Disparities	Salon 217
	Performance Outcomes	Santa Clemente
12:00 p.m.	**LUNCH** on your own	
1:30 p.m. To 5:00 p.m.	Legislative Committee Workforce and Employment Committee	San Clemente Santa Catalina

Thursday, June 21, 2018		**Room**
8:30 a.m. To 12:00 p.m.	Systems and Medicaid Committee Housing and Homelessness Committee	Redondo Room Malibu Room
12:00 p.m.	**LUNCH** on your own	

PLANNING COUNCIL GENERAL SESSION **TAB**

Hermosa Laguna Ballroom

Conference Call 1-877-951-3290 (Listen Only)

Participant Code: 8936702#

1:30 p.m. **Welcome and Introductions**
Raja Mitry, Chairperson

1:40 p.m. **Opening Remarks**
Jonathan E. Sherin, M.D., Ph.D., Director,
Los Angeles County Department of Mental Health

2:00 p.m. **Discussion of Assembly Bill 1971** **L**
Jonathan E. Sherin, M.D., Ph.D., Director,
Los Angeles County Department of Mental Health

2:45 p.m. **Public Comment**

2:55 p.m. **Approval of January 2018 Meeting Minutes** **M**
Raja Mitry, Chairperson

3:00 p.m. **Break**

3:15 p.m. **Approval of Workforce Education and Training 5-Year Plan Budget 2018-19** **N**
Stacie Walker and John Madriz, Workforce Development Division, Office of Statewide Health Planning and Development

3:30 p.m. **Overview of Patients' Rights Advocacy in County Jails and Collaboration with Law Enforcement** **O**
Orange County Health Care Agency, Patients' Rights Advocacy Services
Gerry Aguirre – Service Chief I
Katy Orlando, RN – Patients' Rights Advocate
Patti Yamamoto, RN – Patients' Rights Advocate
Jim Marquez, IMFT – Patients' Rights Advocate

4:30 p.m. **Report from the County Behavioral Health Directors Association**

4:50 p.m. **Public Comment**

5:00 p.m. **Recess**

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

Friday, June 22, 2018

PLANNING COUNCIL GENERAL SESSION CONTINUED **TAB**

Hermosa Laguna Ballroom

Conference Call 1-877-951-3290 (Listen Only)

Participant Code: 8936702

8:30 a.m. **Welcome and Introductions**
Raja Mitry, Chairperson

8:40 a.m. **Report from the California Association of Local Behavioral Health Boards and Commissions**
Theresa Comstock, President, CA Association of Local Behavioral Health Boards and Commissions

9:00 a.m. **Cultural Humility/Awareness** **P**
Tamu Nolfo, PhD

9:55 a.m. **Public Comment**

10:00 a.m. **BREAK**

10:15 a.m. **Cultural Humility/Awareness Continued**
Tamu Nolfo, PhD

11:50 a.m. **Public Comment**

12:00 p.m. **ADJOURN**

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

If a Reasonable Accommodation is required, please contact Jenny Donaldson at 916.322.0962 by June 11, 2018 in order to work with the venue to meet the request.

For 2018 and 2019 Meeting dates visit our CBHPC Quarterly Meetings Page at http://www.dhcs.ca.gov/services/MH/Pages/CBHPC_QuarterlyMeetings.aspx

Executive Committee

Wednesday, June 20, 2018

Sheraton Gateway Hotel
6101 West Century Boulevard
Los Angeles, CA 90045
San Clemente Room
8:30a.m. to 10:15 a.m.

Time	Topic	Presenter or Facilitator	Tab
8:30	Welcome and Introductions	Raja Mitry, Chairperson	
8:35	April and May 2018 Executive Committee Minutes	Raja Mitry, Chairperson	1
8:45	FY 2017-18 Council Budget and Expenditures and Update on Contract Funding Use	Jenny Donaldson, Council Chief of Operations	2
9:00	Discussion of Proposed Policy and Possible New Member from Office of Health Equity	Raja Mitry and Jane Adcock	3
9:10	Discussion of New Council Committees/Ad hoc/Caucuses	Raja Mitry and All	4
9:25	Review Council Vision Statement and Guiding Principles	Raja Mitry and All	5
9:45	Discuss Use of 2003 MH Master Plan Crosswalk	Jane Adcock and All	6
10:00	Liaison Reports for CA Assoc of Local BH Boards/Commissions and CA Coalition for MH	Susan Wilson and Daphne Shaw	
10:10	Public Comment	Raja Mitry, Chairperson	
10:15	Adjourn		

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

Executive Committee Members:

Officer Team	Raja Mitry	Lorraine Flores	Susan Wilson
Advocacy Cmte	Monica Wilson	Darlene Prettyman	
EQI Cmte	Walter Shwe	Susan Wilson	
HCI Cmte	Deborah Pitts	Liz Oseguera	
Patients' Rights	Daphne Shaw	Walter Shwe	
Liaisons	Daphne Shaw, CCMH	Susan Wilson, CALBHB/C	Noel O'Neill, CBHDA

	Kimberly Wimberly, DHCS		
At Large	Arden Tucker, Consumer		
CMHPC Staff	Jane Adcock, EO	Jenny Donaldson, COO	Dorinda Wiseman, Deputy EO

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

California Behavioral Health Planning Council

Patients' Rights Committee

Wednesday, June 20, 2018
Sheraton Gateway Hotel
6101 West Century Boulevard, Los Angeles, CA, 90045
Santa Catalina Room
10:30 a.m. to 12:30 p.m.

Item	Time	Topic	Presenter or Facilitator	Tab
1	10:30 a.m.	Welcome, Introductions, & Agenda Review	Daphne Shaw, Chairperson	
2	10:35	Review and approve April Meeting Minutes	Daphne Shaw and All	A
3	10:40	Update on PRA Legislation and Training Certification	Daphne Shaw & Samuel Jain	
4	11:00	Presentation: The Turning Point ACLU report	Kellen Russoniello	B
5	11:45	Patients' Rights and Mental Health in Jails: Discussion, Recommendations, Plan for Next Meeting	Daphne Shaw and All	C
6	12:25	Public Comment	Daphne Shaw and All	
7	12:30	Adjourn	All	

Committee Members:

Chairperson: Daphne Shaw

Members: Carmen Lee, Walter Shwe, Darlene Prettyman, Catherine Moore, Richard Krzyzanowski, Samuel Jain

Staff: Justin Boese

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

Legislation Committee
Wednesday, June 20, 2018
Sheraton Gateway Los Angeles
6101 West Century Boulevard
Los Angeles, California 90045
San Clemente Room
1:30 p.m. to 5:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
1:30 pm	Welcome and Introductions	Monica Wilson, Chairperson	
1:40	Agenda Review	Monica Wilson, Chairperson	
1:45	Discussion of Chairperson and Chairperson-Elect positions	Staff and All	A
2:00	Approval of Minutes from April 2018 (Advocacy Cmte)	Chairperson and All	B
2:10	Overview and Discussion: Legislative Process	Staff and All	C
2:30	Legislation and regulatory proposals related to Behavioral Health may be discussed.	Staff and All	D
2:55	Public Comment		
3:00	Break		
3:15	Legislation Committee Charter	Chairperson and All	E
4:05	Public Comment		
4:10	Discussion: Legislative Work Plan and Coordination with Housing and Homelessness Committee (ARF Project)	Chairperson, Staff and All	F
4:45	Wrap-Up, Questions, Comments and/or Recommendations	Chairperson and All	
4:55	Public Comment		
5:00 pm	Adjourn		

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

Chairperson:	Monica Wilson	**Chairperson Elect:**	Darlene Prettyman
Members:	Barbara Mitchell	Carmen Lee	Catherine Moore
	Daphne Shaw	Gerald White	Deborah Starkey
	Gail Nickerson	Monica Nepomuceno	Ginny Puddefoot
	Marina Rangel	Patricia Bennett	Raja Mitry
	Noel O'Neill	Simon Vue	Susan Wilson
	Robert Blackford	Veronica Kelley	
Staff:	Jane Adcock	Eva Smith	

If reasonable accommodations are required, please contact the Council at (916) 323-4501 <u>not less</u> than 5 working days prior to the meeting date.

AGENDA

Housing and Homelessness (HHC) Committee
June 21, 2018
Sheraton Gateway Los Angeles Hotel
6101 West Century Boulevard
Los Angeles, CA 90045
8:30am – 12:00pm
Malibu Room

Time	Topic	Presenter or Facilitator	Tab
8:30am	Welcome and Introduction	Eva Smith and All	
8:35am	Nominate Committee Chairperson and Chair-Elect	Eva Smith and All	
8:40am	Discuss and Approve Committee Charter	Chairperson and All	A
9:00am	Review and Discuss Housing and Homelessness Background Information	Eva Smith and All	B
10:00am	**BREAK**		
10:15am	Review and Discuss Current Legislation Related to Housing and Homelessness	Eva Smith and All	C
10:45am	Discuss Adult Residential Facility (ARF) Project	Chairperson and All	D
11:10am	Discuss and Develop Work Plan Priorities	Chairperson and All	E
11:45am	Public Comment	Chairperson	
11:50am	Evaluate Meeting and Develop Next Meeting Agenda	Chairperson and All	
12:00pm	Adjourn		

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

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, June 21, 2018
8:30 a.m. to 12:00 p.m.
Sheraton Gateway Los Angeles Hotel
6101 West Century Boulevard
Los Angeles, CA 90045
Redondo Room

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Welcome and Introductions	Deborah Pitts, Committee Member	
8:35 a.m.	Nomination of Committee Officers	Deborah Pitts, Committee Member	A
8:55 a.m.	Committee Charter Development	Deborah Pitts, Committee Member Committee Chairperson Committee Chair-Elect	B
9:30 a.m.	1115 and 1915(b) Waivers Overview	Deborah Pitts, Committee Member Veronica Kelley, Committee Member	C
10:00 a.m.	Break		
10:15 a.m.	County Behavioral Health Leaders: Facing Today's Challenges and Shaping Public Policy for Our Future	Veronica Kelley, Committee Member	D
11:00 a.m.	Work Plan Development	Committee Chairperson and All	E
11:45 a.m.	Public Comment		
11:50 a.m.	Wrap up: Report Out/Evaluate Meeting	Committee Chairperson	
12:00 p.m.	Adjourn		

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

Committee Members:

Catherine Moore	Deborah Pitts	Kimberly Wimberly	Robert Blackford
Cheryl Treadwell	Liz Oseguera	Marina Rangel	Susan Wilson
Dale Mueller	Karen Hart	Monica Nepomuceno	Veronica Kelley
Daphne Shaw	Kathi Mowers-Moore	Noel O'Neil	Walter Shwe

Staff:
Naomi Ramirez

If reasonable accommodations are required, please contact Naomi Ramirez at (916) 322-3071 not less than 5 working days prior to the meeting date.

California Behavioral Health Planning Council

Workforce and Employment Committee

Wednesday, June 20, 2018
Sheraton Gateway Hotel
6101 West Century Boulevard, Los Angeles, CA, 90045
Santa Catalina Room
1:30 p.m. to 5:00 p.m.

Item	Time	Topic	Presenter or Facilitator	Tab
1	1:30 pm	Introductions & Agenda Review	Justin Boese and All	
2	1:35	Nomination of Chairperson and Chairperson-Elect Positions	All	
3	1:45	Overview and Discussion: Workforce and Employment	Justin Boese and All	A
4	2:15	Public Comment		
5	2:20	Workforce and Employment Committee Charter	Justin Boese and All	B
6	2:40	Public Comment		
7	2:45	Break	All	
8	3:00	Process for next WET 5-Year Plan	OSHPD	C
9	4:55	Public Comment		
10	5:00	Adjourn		

Committee Members:

Members: Walter Shwe, Arden Tucker, Kimberly Wimberly, Vera Calloway, Karen Hart, Cheryl Treadwell, Deborah Pitts, Steve Leoni, Lorraine Flores, Liz Oseguera, Kathy Mowers-Moore, Dale Mueller

Staff: Justin Boese, Naomi Ramirez

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

Committee Officers:
Chair: TBD
Chair-Elect: TBD

Committee Members:
Raja Mitry, Lorraine Flores, Gerald White, Celeste Hunter, Arden Tucker, Barbara Mitchell, Carmen Lee, Darlene Prettyman, Gail Nickerson, Patricia Bennett, Deborah Starkey, Vera Calloway, Monica Wilson, Simon Vue, Steve Leoni, Ginny Puddefoot

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

RESTAURANTS NEAR SHERATON GATEWAY LOS ANGELES HOTEL

Starbucks
6101 W. Century Blvd
0.0 Miles
Cuisines: Café, Fast Food, American

Costero California Bar & Bistro
6101 W. Century Blvd
0.0 Miles
Cuisines: American, Bar, Seafood, Pub

California Pizza Kitchen
6053 W. Century Blvd Ste. 1100
0.1 miles
Cuisines: American, Pizza

Brasserie
6101 W. Century Blvd
0.0 miles
Cuisines: American

Waypoint Kitchen
6151 W. Century Blvd H Hotel
0.1 miles
Cuisines: American

Yokoso Sushi Bar
5985 W. Century Blvd Crowne Plaza
Los Angeles International Airport
0.1 miles
Cuisines: Sushi, Asian

The Original Rinaldi's
6171 W. Century Blvd
0.1 miles
Cuisines: American

Zpizza
5933 W. Century Blvd
0.2 miles
Cuisines: American, Pizza, Italian

Jersey Mike's Subs
5933 W. Century Blvd
0.2 miles
Cuisines: Delicatessen

Unity LA Restaurant
6225 W. Century Blvd
0.2 miles
Cuisines: Mixed

JW's Steakhouse
5855 W. Century Blvd
0.4 miles
Cuisines: American, Steakhouse

Palmira
6225 W. Century Blvd
0.2 miles
Cuisines: American, Italian

Aliki's Greek Taverna
5862 Arbor Vitae St
0.5 miles
Cuisines: Mediterranean, Greek

In-N-Out Burger
9149 S. Sepulveda Blvd
0.6 miles
Cuisines: American, Fast Food

Burger King
9601 Airport Blvd
0.3 miles
Cuisines: American, Fast Food

Truxton's American Bistro
8611 Truxton Ave
0.9 miles
Cuisines: American, Bar

Hanger 18
5855 W. Century Blvd
0.4 miles
Cuisines: American, Bar, Pub

Melody Bar and Grill
9132 S. Sepulveda Blvd
0.6 miles
Cuisines: American, Bar, Pizza, Café

Trimana
5757 W Century Blvd #101
0.5 miles
Cuisines: Café

Togo's
6316 W 89th St
0.7 miles
Cuisines: Sandwiches

Landings
5711 W Century Blvd. Hilton LAX
0.5 miles
Cuisines: American, Bar

Daily Grill on Century
5400 W Century Blvd
1 mile
Cuisines: American

Denny's – Century Blvd
5535 W Century Blvd
0.8 miles
Cuisines: American, Diner

Jino's Pars
5844 W Manchester Ave
1 mile
Cuisines: Middle Eastern, Persian, Italian

Carl's Jr.
5625 W Century Blvd
0.7 miles
Cuisines: American, Fast Food

Andiamo
5711 W Century Blvd
0.5 miles
Cuisines: Italian, International

Luckyfish
116 World Way #198
Great hall, 5th Level
0.4 miles
Cuisines: Japanese, Sushi

The Cafe
5711 W Century Blvd Hilton
0.5 miles
Cuisines: American, Cafe

Sizzler
5856 W Manchester Ave
1 mile
Cuisines: Steakhouse

Paco's Tacos
6212 W Manchester Ave
0.9 miles
Cuisines: Mexican, Latin

Kanpai Sushi Bar and Grill
8736 S Sepulveda Blvd
0.8 miles
Cuisines: Sushi, Asian

Wacky Wok
8919 S Sepulveda Blvd
0.7 miles
Cuisines: Chinese, Asian

Panera Bread
8647 S Sepulveda Blvd
0.9 miles
Cuisines: American, Soups

IHOP
8600 S Sepulveda Blvd
1 mile
Cuisines: American

__**L**___ **TAB SECTION** **DATE OF MEETING** 6/21/18

MATERIAL PREPARED BY: Adcock **DATE MATERIAL PREPARED** 5/29/17

AGENDA ITEM:	Discussion of Assembly Bill 1971
ENCLOSURES:	Assembly Bill 1971 Fact Sheet for AB 1971 Assembly Analysis of AB 1971

How this agenda item relates to the Council's Mission.

The CBHPC evaluates the behavioral health system for accessible and effective care. It advocates for an accountable system of responsive services that are strength-based, recovery-oriented, culturally and linguistically competent, and cost-effective. To achieve these ends, the Council educates the public, the behavioral health constituency, and legislators.

This agenda item brings forth a discussion regarding the difficult subject of involuntary detention. The Council will hear the perspective of the organization sponsoring the legislation to make a change in law to include a person's inability to provide for his/her own basic personal needs for health as an additional element of the grave disability standard for involuntary detention.

Background/Description:

Jonathan E. Sherrin, M.D., Ph.D., Director for the Los Angeles County Department of Mental Health will discuss with the Council his reasons and perspective regarding the need for this legislative addition to the "gravely disabled" standard under the Welfare and Institutions Code.

A copy of the most recent version of the bill, a Fact Sheet, and an analysis done for the Assembly are enclosed. The first page of the bill includes the legislative findings which discuss the crisis of homelessness and increasing reports of untreated medical conditions that endanger the well-being of individuals and in some cases, worsen into serious medical emergencies and/or death. The Fact Sheet and analysis provide more information and detail about the proposed changed, which sections of the Welfare and Institutions Code are being amended and why.

AMENDED IN ASSEMBLY APRIL 12, 2018

AMENDED IN ASSEMBLY MARCH 15, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1971

Introduced by Assembly Members ~~Santiago and Friedman~~ *Santiago, Chen, and Friedman*
(Coauthors: Assembly Members Maienschein and McCarty)
(Coauthor: Senator Dodd)

January 31, 2018

An act to amend Section 1799.111 of the Health and Safety Code, and to amend Sections 5008, 5250, and 5350 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1971, as amended, Santiago. Mental health services: involuntary detention: gravely disabled.

Existing law, the Lanterman-Petris-Short Act, authorizes the involuntary commitment and treatment of persons with specified mental health disorders for the protection of the persons so committed. Under the act, if a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or is gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, a member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or another designated professional person, and placed in a facility designated by the county and approved by the State Department of Social Services as a facility for 72-hour treatment and evaluation. For these purposes, existing law defines "gravely disabled" to mean either a condition in which a person, as a result of a mental

health disorder or chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing, or shelter, or a condition in which a person has been found mentally incompetent, as specified. Existing law also provides immunity from civil and criminal liability for the detention by specified licensed general acute care hospitals, licensed acute psychiatric hospitals, licensed professional staff at those hospitals, or any physician and surgeon providing emergency medical services in any department of those hospitals if various conditions are met, including that the detained person cannot be safely released from the hospital because, in the opinion of treating staff, the person, as a result of a mental health disorder, presents a danger to himself or herself, or others, or is gravely disabled, as defined.

This bill would expand ~~that~~ *the* definition of "gravely disabled" for these purposes to also include a condition in which a person, as a result of a mental health disorder or chronic alcoholism, as applicable, is unable to provide for his or her medical treatment, as specified. The bill would make conforming changes. *The bill would make certain legislative findings and declarations related to mental health.*

Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant is committed to a facility for treatment. If the defendant is gravely disabled, as defined above, upon his or her return to the committing court, existing law requires the court to order the conservatorship investigator of the county to initiate conservatorship proceedings on the basis that the indictment or information pending against the person charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.

By expanding the above definition of "gravely disabled," the bill would increase the duties on local agencies, and would therefore impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The large and growing number of persons with mental health disabilities living on the streets and revolving in and out of hospitals, jails, and prisons in the state is a problem of serious concern for California counties.

(b) Data from the State Department of Health Care Services for the 2015–16 fiscal year identified 94,133 individuals received outpatient mental health services in county jails and 2,356 individuals were admitted to jail-based psychiatric inpatient units. The Department of Corrections and Rehabilitation estimates that among the 129,000 inmates receiving prison-based mental health services, approximately 35,000 individuals have severe mental illness.

(c) Expert consensus identifies a number of factors contributing to the crises of homelessness and the criminalization of persons with severe mental illness, among which are insufficient community resources, including both psychiatric inpatient and outpatient treatment options, as well as appropriate affordable housing options.

(d) Among the population of homeless persons with a severe mental illness, there are increasing reports of untreated medical conditions that endanger the health and well-being of those individuals. In far too many cases, these conditions worsen into serious medical emergencies, a number of which tragically result in death.

(e) Data from the State Department of Health Care Services for the 2015–16 fiscal year also identifies the following involuntary detentions for persons with severe mental illness by category:

(1) 72-hour adult holds for evaluation and treatment for 136,874 individuals.

(2) 14-day intensive treatment holds for 55,870 individuals.

(3) 30-day intensive treatment holds for 3,514 individuals.

(4) Temporary conservatorships for 1,955 individuals.

(5) Permanent conservatorships for 4,643 individuals.

(f) The criteria for grave disability, which is defined as an inability to provide for one's own basic personal needs for food, clothing, and shelter as a basis for detention and treatment under these holds, has been identified as a source of concern for several reasons.

(1) The grave disability criteria is subject to various interpretations statewide, resulting in unequal application of the law from county to county.

(2) Existing law does not recognize the inability of an individual to provide for his or her own basic personal needs for health as an element contributing to grave disability, resulting in many avoidable tragedies that directly stem from the neglect of medical conditions.

(g) It is therefore the intent of the Legislature to include a person's inability to provide for his or her basic personal needs for health as an additional element of the grave disability standard, consistent with the original aims of the Lanterman-Petris-Short Act, which seeks to:

(1) Provide prompt evaluation and treatment of persons with mental health disorders.

(2) Provide individualized treatment, supervision, and placement services by conservatorship for persons gravely disabled.

(3) Safeguard individual rights through judicial review.

(4) Provide services in the least restrictive setting appropriate to the needs of each person receiving services.

(h) The Legislature recognizes that application of this clarifying standard may provide earlier intervention than what is currently possible. It is the intent of the Legislature in applying this clarifying standard to prevent the further deterioration of a person's health and mental health condition, avoid the need for more intensive and costly interventions later on, avoid increased morbidity and mortality, reduce homelessness, and decrease the prevalence of severe mental illness in our jails and prisons. This standard will allow more efficient use of existing resources to treat more people at lower levels of care, effectively freeing up dollars formerly spent on higher levels of care for use in the mental health system generally.

(i) The Legislature also recognizes that this clarifying standard will allow some individuals who are now neglected because they do not fall under the current varying interpretations of the gravely

disabled standard, to access substitute decisionmakers in the form of conservators appointed to assist them in stabilizing their illnesses and support them on their path of recovery.

(j) In order to provide more consistent interpretations of the definition of "gravely disabled," the Legislature also declares that counties should consider, to the extent possible, the individual's ability to make informed decisions about providing for his or her own basic needs for food, clothing, shelter, or medical treatment.

~~SECTION 1.~~

SEC. 2. Section 1799.111 of the Health and Safety Code is amended to read:

1799.111. (a) Subject to subdivision (b), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital is not civilly or criminally liable for detaining a person if all of the following conditions exist during the detention:

(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental health disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, "gravely disabled" ~~means an inability to provide for his or her basic personal needs for food, clothing, shelter, or medical treatment, if the lack of, or failure to receive, that treatment may result in substantial physical harm or death.~~ *has the same meaning as that term is defined in paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code.*

(2) The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

(A) Telephone calls or other contacts required pursuant to this paragraph shall commence at the earliest possible time when the treating physician and surgeon has determined the time at which the person will be medically stable for transfer.

(B) In no case shall the contacts required pursuant to this paragraph begin after the time when the person becomes medically stable for transfer.

(3) The person is not detained beyond 24 hours.

(4) There is probable cause for the detention.

(b) If the person is detained pursuant to subdivision (a) beyond eight hours, but less than 24 hours, both of the following additional conditions shall be met:

(1) A discharge or transfer for appropriate evaluation or treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

(2) In the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a mental health disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph (1) of subdivision (a).

(c) In addition to the immunities set forth in subdivision (a), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital as defined by subdivision (b) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to subdivision (a) after that person’s release from the detention at the hospital, if all of the following conditions exist during the detention:

(1) The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.

(2) The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the person detained, that the person does not present a danger to himself or herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and the clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.

(d) This section does not affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

(e) A person detained under this section shall be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

(f) The amendments to this section made by the act adding this subdivision shall not be construed to limit any existing duties for psychotherapists contained in Section 43.92 of the Civil Code.

(g) This section does not expand the scope of licensure of clinical psychologists.

~~SEC. 2.~~

SEC. 3. Section 5008 of the Welfare and Institutions Code is amended to read:

5008. Unless the context otherwise requires, the following definitions shall govern the construction of this part:

(a) "Evaluation" consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions as may appear to constitute a problem. Persons providing evaluation services shall be properly qualified professionals and may be full-time employees of an agency providing face-to-face, which includes telehealth, evaluation services or may be part-time employees or may be employed on a contractual basis.

(b) "Court-ordered evaluation" means an evaluation ordered by a superior court pursuant to Article 2 (commencing with Section 5200) or by a superior court pursuant to Article 3 (commencing with Section 5225) of Chapter 2.

(c) "Intensive treatment" consists of hospital and other services as may be indicated. Intensive treatment shall be provided by properly qualified professionals and carried out in facilities qualifying for reimbursement under the California Medical Assistance Program (Medi-Cal) set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9, or under Title XVIII of the federal Social Security Act and regulations thereunder. Intensive treatment may be provided in hospitals of the United States government by properly qualified professionals. This part does not prohibit an intensive treatment facility from also providing 72-hour evaluation and treatment.

(d) "Referral" is referral of persons by each agency or facility providing assessment, evaluation, crisis intervention, or treatment services to other agencies or individuals. The purpose of referral shall be to provide for continuity of care, and may include, but need not be limited to, informing the person of available services, making appointments on the person's behalf, discussing the person's problem with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for personal escort and transportation when necessary. Referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services. All persons shall be advised of available precare services that prevent initial recourse to hospital treatment or aftercare services that support adjustment to community living following hospital treatment. These services may be provided through county or city mental health departments, state hospitals under the jurisdiction of the

State Department of State Hospitals, regional centers under contract with the State Department of Developmental Services, or other public or private entities.

Each agency or facility providing evaluation services shall maintain a current and comprehensive file of all community services, both public and private. These files shall contain current agreements with agencies or individuals accepting referrals, as well as appraisals of the results of past referrals.

(e) "Crisis intervention" consists of an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations which present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with such therapy, or other services, as may be appropriate. The interview or interviews may include family members, significant support persons, providers, or other entities or individuals, as appropriate and as authorized by law. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services.

(f) "Prepetition screening" is a screening of all petitions for court-ordered evaluation as provided in Article 2 (commencing with Section 5200) of Chapter 2, consisting of a professional review of all petitions; an interview with the petitioner and, whenever possible, the person alleged, as a result of a mental health disorder, to be a danger to others, or to himself or herself, or to be gravely disabled, to assess the problem and explain the petition; when indicated, efforts to persuade the person to receive, on a voluntary basis, comprehensive evaluation, crisis intervention, referral, and other services specified in this part.

(g) "Conservatorship investigation" means investigation by an agency appointed or designated by the governing body of cases in which conservatorship is recommended pursuant to Chapter 3 (commencing with Section 5350).

(h) (1) For purposes of Article 1 (commencing with Section 5150), Article 2 (commencing with Section 5200), and Article 4 (commencing with Section 5250) of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means either of the following:

(A) A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, shelter, or medical treatment, if the ~~lack of, or failure to receive, that treatment may result in substantial physical harm or death~~ *failure to receive medical treatment results in a deteriorating physical condition or death. For purposes of this subdivision, "medical treatment" means the administration or application of remedies for a mental health condition, as identified by a licensed mental health professional, or a physical health condition, as identified by a licensed medical professional.*

(B) A condition in which a person, has been found mentally incompetent under Section 1370 of the Penal Code and all of the following facts exist:

(i) The complaint, indictment, or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.

(ii) There has been a finding of probable cause on a complaint pursuant to paragraph (2) of subdivision (a) of Section 1368.1 of the Penal Code, a preliminary examination pursuant to Section 859b of the Penal Code, or a grand jury indictment, and the complaint, indictment, or information has not been dismissed.

(iii) As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceedings taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner.

(iv) The person represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder.

(2) For purposes of Article 3 (commencing with Section 5225) and Article 4 (commencing with Section 5250), of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means a condition in which a person, as a result of impairment by chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

(3) The term "gravely disabled" does not include persons with intellectual disabilities by reason of that disability alone.

(i) "Peace officer" means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer

Standards and Training, or any parole officer or probation officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility.

(j) "Postcertification treatment" means an additional period of treatment pursuant to Article 6 (commencing with Section 5300) of Chapter 2.

(k) "Court," unless otherwise specified, means a court of record.

(*l*) "Antipsychotic medication" means any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders.

(m) "Emergency" means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

(n) "Designated facility" or "facility designated by the county for evaluation and treatment" means a facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code, by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit.

~~SEC. 3.~~

SEC. 4. Section 5250 of the Welfare and Institutions Code is amended to read:

5250. If a person is detained for 72 hours under the provisions of Article 1 (commencing with Section 5150), or under court order for evaluation pursuant to Article 2 (commencing with Section 5200) or Article 3 (commencing with Section 5225) and has received an evaluation, he or she may be certified for not more than 14 days of intensive treatment related to the mental health disorder or impairment by chronic alcoholism, under the following conditions:

(a) The professional staff of the agency or facility providing evaluation services has analyzed the person's condition and has found the person is, as a result of a mental health disorder or impairment by chronic alcoholism, a danger to others, or to himself or herself, or gravely disabled.

(b) The facility providing intensive treatment is designated by the county to provide intensive treatment, and agrees to admit the person. No facility shall be designated to provide intensive treatment unless it complies with the certification review hearing required by this article. The procedures shall be described in the county Short-Doyle plan as required by Section 5651.3.

(c) The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.

(d) (1) Notwithstanding paragraph (1) of subdivision (h) of Section 5008, a person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, ~~or~~ shelter, or medical treatment.

(2) However, unless they specifically indicate in writing their willingness and ability to help, family, friends, or others shall not be considered willing or able to provide this help.

(3) The purpose of this subdivision is to avoid the necessity for, and the harmful effects of, requiring family, friends, and others to publicly state, and requiring the certification review officer to publicly find, that no one is willing or able to assist a person with a mental health disorder in providing for the person's basic needs for food, clothing, ~~or~~ shelter, or medical treatment.

~~SEC. 4.~~

SEC. 5. Section 5350 of the Welfare and Institutions Code is amended to read:

5350. A conservator of the person, of the estate, or of the person and the estate may be appointed for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism.

The procedure for establishing, administering, and terminating a conservatorship under this chapter shall be the same as that provided in Division 4 (commencing with Section 1400) of the Probate Code, except as follows:

(a) A conservator may be appointed for a gravely disabled minor.

(b) (1) Appointment of a conservator under this part, including the appointment of a conservator for a person who is gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008, shall be subject to the list of

priorities in Section 1812 of the Probate Code unless the officer providing conservatorship investigation recommends otherwise to the superior court.

(2) In appointing a conservator, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008, the court shall consider the purposes of protection of the public and the treatment of the conservatee. Notwithstanding any other provision of this section, the court shall not appoint the proposed conservator if the court determines that appointment of the proposed conservator will not result in adequate protection of the public.

(c) No conservatorship of the estate pursuant to this chapter shall be established if a conservatorship or guardianship of the estate exists under the Probate Code. When a gravely disabled person already has a guardian or conservator of the person appointed under the Probate Code, the proceedings under this chapter shall not terminate the prior proceedings but shall be concurrent with and superior thereto. The superior court may appoint the existing guardian or conservator of the person or another person as conservator of the person under this chapter.

(d) (1) The person for whom conservatorship is sought shall have the right to demand a court or jury trial on the issue of whether he or she is gravely disabled. Demand for court or jury trial shall be made within five days following the hearing on the conservatorship petition. If the proposed conservatee demands a court or jury trial before the date of the hearing as provided for in Section 5365, the demand shall constitute a waiver of the hearing.

(2) Court or jury trial shall commence within 10 days of the date of the demand, except that the court shall continue the trial date for a period not to exceed 15 days upon the request of counsel for the proposed conservatee.

(3) This right shall also apply in subsequent proceedings to reestablish conservatorship.

(e) (1) Notwithstanding subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008, a person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, ~~or~~ shelter, or medical treatment.

(2) However, unless they specifically indicate in writing their willingness and ability to help, family, friends, or others shall not be considered willing or able to provide this help.

(3) The purpose of this subdivision is to avoid the necessity for, and the harmful effects of, requiring family, friends, and others to publicly state, and requiring the court to publicly find, that no one is willing or able to assist a person with a mental health disorder in providing for the person's basic needs for food, clothing, ~~or~~ shelter, or medical treatment.

(4) This subdivision does not apply to a person who is gravely disabled, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008.

(f) Conservatorship investigation shall be conducted pursuant to this part and shall not be subject to Section 1826 or Chapter 2 (commencing with Section 1850) of Part 3 of Division 4 of the Probate Code.

(g) Notice of proceedings under this chapter shall be given to a guardian or conservator of the person or estate of the proposed conservatee appointed under the Probate Code.

(h) As otherwise provided in this chapter.

~~SEC. 5.~~

SEC. 6. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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AB 1971 (Santiago, Friedman, and Chen)
Gravely Disabled

Bill Summary

AB 1971 expands the definition of "gravely disabled" to include medical treatment where the inability or failure to receive medical treatment will result in a deteriorating physical condition or death.

Existing Law

State law defines "gravely disabled" as a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter (WIC § 5008 and HSC § 1799.111).

WIC § 5150 states that when a person, as a result of a mental health disorder, is a danger to others or himself/herself, or is gravely disabled, a peace officer, county professional, a mobile crisis team, may take a person into custody for 72 hours for assessment, evaluation, crisis intervention, or placement for treatment in a facility designated by the county.

WIC § 5250 states that an individual may receive intensive treatment related to their mental health disorder or impairment of alcoholism for not more than 14 days after an evaluation has been made by a psychiatric nurse.

WIC § 5350 provides that a court may order a conservator to be appointed for a person who is gravely disabled as a result of a mental health disorder, so long as the condition of gravely disabled is proven beyond a reasonable doubt.

Background

Conservatorship is a legal term referring to the legal responsibilities of a conservator over the affairs of a person who has been deemed "gravely disabled" by the court and unable to meet his or her basic needs of food, clothing, or shelter. The purpose of conservatorship is to provide individualized treatment and supervision.

On October 31, 2017, the Los Angeles County Board of Supervisors approved a motion jointly authored by Supervisors Kathryn Barger and Mark Ridley-Thomas that directed the County's Department of Mental Health (LADMH) to work with county agencies, mental health advocacy groups, civil rights organizations, and other stakeholders to develop legislative recommendations to tackle the growing number of homeless deaths in Los Angeles County. Numerous mental health professionals and advocates voiced support and participated in the effort.

Need for AB 1971

According to local data, there is an increased death rate among the homeless population in Los Angeles County. A significant number of these deaths were due to preventable and/or treatable medical conditions such as cardiovascular disease, pneumonia, diabetes, cancer, cirrhosis, severe bacterial infection, and other treatable conditions. Although these numbers do not indicate whether or not the deceased homeless individuals suffered from mental illness that impaired their willingness to seek care, Los Angeles County has seen a 28 percent increase in homeless individuals suffering from a mental illness from 2015-2017.

Currently, state law fails to address the needs of those with a mental illness that are unable to provide for their urgently needed medical treatment. Often times an individual's mental illness acts as a barrier to them accepting such medical care. Unfortunately, these individuals are at the highest risk of dying on the streets. Leaving people on the streets that are mentally ill and in need of medical attention to become severely ill and less functional is inhumane.

AB 1971 will change the definition of "gravely disabled" to consider urgently needed medical treatment as a basic human need when assessing an individual's need for conservatorship or need for a 72 hour hold while maintaining all statutorily protected safeguards and civil liberties.

Support

Los Angeles County (Sponsor)
California Psychiatric Association (Co-Sponsor)
Steinberg Institute (Co-Sponsor)
African Communities Public Health Coalition
California Academy of Child & Adolescent Psychiatry
Cause Communications
Church of the Blessed Sacrament
City of Los Angeles
City of Monrovia
City of Santa Monica
City of West Covina
Governing Board of the San Gabriel Valley Council of Governments
Homeless Health Care Los Angeles
Los Angeles Councilmember David E. Ryu
Los Angeles County Mental Health Commission
Los Angeles County Sheriff's Department
Solano County Board Supervisor District 2, Monica Brown
National Alliance on Mental Illness Los Angeles County Council
National Alliance on Mental Illness Sacramento
Service Area Two's Advisory Council
Special Service for Groups, Inc.
The California Treatment Advocacy Coalition
The Roy Smith Charitable Foundation
Valley Industry and Commerce Association
West Covina City Council
3 Individuals

Opposition

American Civil Liberties Union
California Advocates for Nurse Home Reform
California Association of Mental Health Patients' Rights Advocates
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Behavioral Health Planning Council
California Pan-Ethnic Health Network
Coalition on Homelessness San Francisco
Disability Rights California
Disability Rights Education and Defense Fund
Law Foundation of Silicon Valley
National Health Law Project
Sacramento Regional Coalition to End Homelessness
Western Center on Law and Poverty

For More Information

Marilyn Limon
Assemblymember Miguel Santiago, AD53
916-319-2053 | Marilyn.Limon@asm.ca.gov

ASSEMBLY THIRD READING
AB 1971 (Santiago, et al.)
As Amended April 12, 2018
Majority vote

Committee	Votes	Ayes	Noes
Health	15-0	Wood, Mayes, Aguiar-Curry, Bigelow, Bonta, Burke, Carrillo, Flora, Limón, McCarty, Nazarian, Rodriguez, Santiago, Thurmond, Waldron	
Appropriations	16-0	Gonzalez Fletcher, Bigelow, Bloom, Bonta, Calderon, Carrillo, Chau, Eggman, Fong, Friedman, Gallagher, Eduardo Garcia, Nazarian, Obernolte, Quirk, Reyes	

SUMMARY: Expands, the definition of "gravely disabled" to mean a person's inability to provide for their basic personal needs for food, clothing, shelter, or medical treatment if the lack of, or failure to receive, that treatment may result in substantial physical harm or death for purposes of involuntary holds and detentions.

EXISTING LAW:

1) Defines "gravely disabled" as a person's inability to provide for their basic personal needs for food, clothing, or shelter.

2) Provides for the involuntary commitment and treatment of individuals with specified mental disorders and for the protection of committed individuals, with the declared goal of ending inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism.

3) Creates a series of processes for individuals to receive mental health treatment while being held involuntarily, known as a "5150 hold," including:

    a) A process for a person to be taken into custody, upon probable cause that they are a danger to self, a danger to others, or gravely disabled as a result of a mental health disorder, for a period of up to 72 hours, as specified;

    b) For a person who has been detained for 72 hours, a process for the person to be detained for up to14 days of intensive treatment if the person continues to pose a danger to self or others, or to be gravely disabled, and the person has been unwilling or unable to accept voluntary treatment;

    c) For a person who has been detained for 14 days of intensive treatment, a process for the person to be detained for up to 30 days of intensive treatment if the person remains gravely disabled and is unwilling or unable to accept treatment voluntarily, or up to 180 days if the person presents a demonstrated danger to others;

d) A process for the appointment of a conservator, known as a Lanterman-Petris-Short (LPS/LPS Act) conservatorship, for a person who has been involuntarily detained and is gravely disabled as a result of a mental disorder or impairment by chronic alcoholism, to provide individualized treatment, supervision, and placement.

4) Establishes "Laura's Law" which permits counties to provide Assisted Outpatient Treatment (AOT) services for people with serious mental illnesses when a court determines that a person's recent history of hospitalizations or violent behavior, and noncompliance with voluntary treatment, indicates the person is likely to become dangerous or gravely disabled without the court-ordered outpatient treatment.

5) Allows a court, after finding that an individual meets the criteria for AOT, and there is no appropriate and feasible less restrictive alternative, to order the individual to receive AOT for an initial period not to exceed six months. If the director of the assisted outpatient program determines that the individual requires further assisted outpatient services, requires that director, prior to expiration of the time period of the treatment, to apply to the court for an extension of the services, not to exceed 180 days.

FISCAL EFFECT: According to the Assembly Appropriations Committee:

1) Unknown, potentially significant costs for some level of increased Medi-Cal enrollment and corresponding health care costs statewide, to the extent individuals currently not seeking medical care or not enrolled in Medi-Cal receive health care treatment as a result of this bill [General Fund (GF)/federal]. Given the bill is intended to encourage treatment for serious and deteriorating health conditions, medical care would likely be fairly intensive and high-cost for individuals affected by this bill, most of whom would likely be Medi-Cal eligible.

2) Potential one-time administrative costs in the low hundreds of thousands of dollars to the Department of Health Care Services over two years, if regulations are necessary to interpret these changes (GF/federal). Any regulations on this topic are likely to elicit significant public engagement.

3) Significant GF cost pressure on state trial courts, potentially in the low millions of dollars, associated with a higher number of case filings for 14-day holds, 30-day holds and conservatorships.

4) Significant costs to counties, potentially in the millions of dollars statewide for additional conservatorship investigations and conservatorships, are not likely to be state-reimbursable. In 2014, the Commission on State Mandates denied a test claim submitted by Los Angeles (LA) County, finding a 2006 law imposing new duties on public guardians is not state-reimbursable since the duties are triggered by the counties' decision to establish offices of public guardian. Because counties are not legally obligated to appoint public conservators, costs for a greater number of investigations are similarly not state-reimbursable. In addition, conservatorships themselves are established not by legislative mandate, but by the courts, and costs to comply with court mandates are not reimbursable.

COMMENTS: According to the author, more than 800 homeless individuals died on the streets of LA County in 2017. It is inhumane to be a bystander when we have the power to do something to save lives. Many of these deaths could have been prevented with suitable medical treatment. The author argues that by changing the definition of "gravely disabled" to consider

urgently needed medical treatment as a basic human need when assessing an individual's need for conservatorship while maintaining all statutorily protected safeguards and civil liberties, we will be one step closer to providing proper medical treatment for homeless individuals with mental illness who are suffering on the streets with serious physical ailments.

Section 5150 of the LPS Act allows peace officers, staff-members of county-designated evaluation facilities, or other county-designated professional persons, to take an individual into custody and place them in a facility for 72-hour treatment and evaluation if they believe that, due to a mental disorder, the individual is a danger to himself, herself, or others, or is gravely disabled – i.e., unable to provide for basic personal needs for food, clothing, or shelter due to a mental disability. The LPS Act, enacted in the 1960s, was intended to balance the goals of maintaining the constitutional right to personal liberty and choice in mental health treatment, with the goal of safety. At the time of its enactment, the LPS Act was considered progressive because it afforded the mentally disordered more legal rights than most other states. Since its passage in 1967, the law in the field of mental health has continued to evolve toward greater legal rights for mentally disordered persons.

1) **LPS conservatorship process**. The LPS Act creates a series of processes for the involuntary treatment of individuals who are unwilling or unable to accept necessary mental health treatment, generally conditional upon the person being gravely disabled or posing a danger to self or others. An LPS conservatorship, which lasts for a year before it must be reinitiated and reapproved, is typically sought after an individual has received 72-hour evaluation and treatment and 14-day intensive treatment and continues to be gravely disabled. The process begins when the professional staff of the psychiatric facility, after having evaluated and treated the individual, makes a recommendation of conservatorship to the county conservatorship investigator (typically designated as an office in the county, such as the Public Guardian's Office or the Office of the Public Conservator). The county conservatorship investigator is then required to conduct a comprehensive investigation and file a petition for conservatorship only if, after considering all available alternatives to conservatorship, there are no suitable alternatives available.

2) **Other definitions**. There is no commonly accepted term for individuals who are gravely disabled or incapacitated; definitions vary widely by state with varying degrees of subjectivity. The State of Oregon defines incapacitated, or incapable of making valid decisions, when an individual can no longer receive and evaluate information effectively or communicate their decisions. The State of Washington defines "gravely disabled" as a condition in which a person, as a result of a mental disorder: a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or, b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving or would not receive, if released, such care as is essential for his or her health or safety.

3) **Assisted Outpatient Treatment**. The AOT Demonstration Project, or Laura's Law, allows courts in participating counties to order a person into an AOT program if the court finds that the individual either meets existing involuntary commitment requirements pursuant to Welfare and Institutions Code Section 5150 (is gravely disabled or is a danger to self or others), or the person meets non-5150 criteria including that the person has refused treatment, their mental health condition is substantially deteriorating, and AOT would be the least

restrictive level of care necessary to ensure the person's recovery and stability in the community. The law is only operative in those counties in which the county board of supervisors, by resolution, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, was reduced in order to implement the law. Currently, Nevada, Orange, Yolo, and the City and County of San Francisco have approved full implementation of Laura's Law. LA County implemented the law on a limited basis in 2003 and expanded the program county-wide in 2015. Initiating the AOT process begins with a referral submitted by family members, relatives, cohabitants, treatment providers or their supervisors, or peace officers. If individuals meet AOT eligibility requirements, a preliminary care plan is developed. If the individual voluntarily engages with the treatment after initial contact, a petition is no longer necessary and the patient no longer meets the criteria for AOT referral. However if the client declines the preliminary care plan, the AOT team proceeds with a petition and a public defender is assigned to the client. The court must be notified within 10 days of the intervention, and a hearing must be set within five days of the filing of the petition and the judge either grants or rejects the AOT petition. If ordered, AOT is valid for up to 180 days.

According to information provided LA County, the County has received 1,365 referrals to the AOT program as of February of 2018. Of those, 873 met the criteria for AOT. Sixty-four percent of AOT referrals originated from a licensed treatment provider, 27% were petitioned by a parent, spouse, sibling, or child, and 9% originated from a peace officer.

The LA County Board of Supervisors, cosponsors of this bill, states that current law does not explicitly address those who, because of their mental health disorder, are unable to seek needed medical treatment. The sponsor argues that this bill would recognize that urgent medical treatment is a basic need as necessary to wellbeing as food, shelter, or clothing and that the bill maintains an individual's right to be heard in court when detained involuntarily and gravely disabled would need to be determined beyond a reasonable doubt thus, maintaining all statutorily protected safeguards and civil liberties under the LPS Act. The LA County Medical Examiner-Coroner (MEC) reports that the number of deaths among the homeless population in LA County continues to increase, with over 830 people dying on the streets in 2017. According to MEC data, many of these deaths could have been prevented had they received proper medical treatment. Homeless individuals with a co-occurring mental illness could disproportionately account for the increase in death rates among the homeless population.

The Steinberg Institute, cosponsor of this bill, states that according to local data, there is an increased death rate among the homeless population in LA County. A significant number of these deaths were due to preventable and/or treatable medical conditions such as cardiovascular disease, pneumonia, diabetes, cancer, cirrhosis, severe bacterial infection, and other treatable conditions. The Steinberg Institute notes that although these numbers do not indicate whether or not the deceased homeless individuals suffered from mental illness that impaired their willingness to seek care, LA County has seen a 28% increase in homeless individuals suffering from a mental illness from 2015 to 2017. The cosponsor concludes that by expanding the "gravely disabled" definition to include consideration of medical need where the lack or failure of such treatment may result in substantial physical harm or death, those involved hope to be able to provide care for more homeless individuals and save lives.

The California Psychiatric Association (CPA), cosponsors of this bill, states that this bill proposes to recognize that health is a basic human need like food, clothing, and shelter, and that

failure or inability to be able to provide for ones health on the part of a person with a mental disorder is grounds to consider them gravely disabled – thus providing equity to, and the same rights and protections as, persons considered gravely disabled because they cannot provide for their basic human needs for food, clothing, or shelter. CPA states that psychiatrists often stand by helplessly watching physical harm overtake individuals so disabled by severe mental illness that they lack the capacity to appreciate health risks they are subject to and cannot or do not act in ways to preserve their health. Psychiatrists are helpless because current law does not allow an intervention on behalf of the welfare of a person severely disabled by a mental illness on the basis of medical risks to which the person is exposing themselves. CPA concludes that the current growing and significant crises of homelessness and criminalization of those with a mental illness are based in part on the very shortcomings in our treatment laws identified as early as 1995. The human costs associated with these shortcomings deserve solutions to reduce them and inaction to update our treatment laws to respond to them is unthinkable to psychiatrists.

The American Civil Liberties Union, the California Association of Mental Health Patients' Rights Advocates, the California Pan-Ethnic Health Network, the Coalition on Homelessness San Francisco, the Law Foundation of Silicon Valley, Disability Rights California, the Sacramento Regional Coalition to End Homelessness, and the Western Center on Law on Poverty all write together as a coalition (Coalition) opposed to the bill. The Coalition states in opposition that the bill: needlessly expands the LPS Act to permit an undefined standard by which to impose involuntary care for individuals in a restrictive and confined environment; proposes a solution that does not meet the sponsors' goals of addressing homelessness and medical care; is dangerously expansive at the expense of individual rights; and, does nothing to ensure that those proposed to be conserved under the expansion will be provided with adequate food, clothing, shelter, or medical and behavioral health care. The Coalition notes that current law already allows for involuntary treatment of individuals unable to carry out transactions necessary for survival or to provide basic needs. Homeless individuals refusing available care for life threatening medical conditions meet this definition and are regularly conserved by courts when found necessary. The Coalition notes that there has been no showing of current barriers in existing law or practice that prevents counties from providing the care and services they propose with this bill.

The Coalition also argues that nothing in this bill expands housing or access to medical services for individuals who are homeless and have behavioral and medical health treatment needs. Expanding voluntary services (e.g. full-service partnerships, permanent supported housing) and access to quality, integrated medical care more cost efficient, more effective, and more humane. Indeed, solutions that foster independence and self-direction are more successful than the forced and involuntary care proposed by this bill. Involuntary treatment means the county has the duty to treat and house the conservatees, which includes making physical and mental health services actually available. This bill puts the cart before the horse since the county is already unable to provide services and housing. The county cannot deliver these services; pretending that the only people who need services are the ones that do not want them is just not a solution.

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097 FN: 0003265

__**M**___ **TAB SECTION** **DATE OF MEETING** 6/21/18

MATERIAL PREPARED BY: Adcock **DATE MATERIAL PREPARED** 5/22/17

AGENDA ITEM:	Approval of Minutes from April 2018 Meeting
ENCLOSURES:	Draft Minutes of April 2018 meeting

BACKGROUND/DESCRIPTION:

Attached are draft minutes for the April 2018 meeting of the California Behavioral Health Planning Council for member review and approval**.**

CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL MEETING MINUTES

April 18-20, 2018
Pullman Hotel
223 Twin Dolphin Drive
Redwood City, CA 94065

CBHPC Members Present:

Raja Mitry, Chairperson
Lorraine Flores, Chair-Elect
Susan Wilson, Past Chair
Robert Blackford
Karen Hart
Celeste Hunter
Veronica Kelley
Carmen Lee
Steve Leoni
Barbara Mitchell
Catherine Moore
Kathi Mowers-Moore
Dale Mueller
Monica Nepomuceno
Gail Nickerson
Noel O'Neill
Liz Oseguera
Deborah Pitts
Darlene Prettyman
Marina Rangel
Daphne Shaw
Walter Shwe
Deborah Starkey
Cheryl Treadwell
Simon Vue
Gerald White
Kimberly Wimberly

Staff Present:

Jane Adcock, Executive Officer
Justin Boese
Linda Dickerson
Jenny Donaldson
Naomi Ramirez
Eva Smith
Dorinda Wiseman

Wednesday, April 18, 2018

1. Welcome and Introductions

Chairperson Raja Mitry opened the meeting. The Planning Council members introduced themselves, stating their counties and representations.

2. Opening Remarks

Patricia Way, Chairperson, San Mateo County Mental Health & Substance Use Recovery Commission, provided opening remarks. She began with an overview of behavior health and recovery services in San Mateo County.

- The adult system of care offers community support services through Mental Health Services Act (MHSA) funding. It complements clinical treatment services.
- Affordable housing is a huge challenge that keeps getting worse. It is hard to manage the mental health and substance abuse condition of clients if they do not have a safe or stable place to live. The county partners with the Department of Housing, but the number of available units is dismal.
- The county has the integration of mental health and Alcohol and Other Drug (AOD) services. San Mateo is one of the first counties to implement Drug Medi-Cal.
- The county has a growing Integrated Medication-Assisted Treatment (IMAT) program. It is an evidence-based program offering medication as part of the person's alcohol and/or drug treatment.
- The county youth system operates a residential treatment facility. It is short-term.
- San Mateo County is the only county contracted to serve people with mild to moderate mental health conditions as well as those with serious mental illness.
- She read from *Welcome to Holland* by Emily Kingsley, about raising a child with a disability.

Planning Council members expressed appreciation for the reading.

3. Approval of Minutes from January 2018 Meeting

Chairperson Mitry requested a Motion for approval of the January Minutes.

> **Motion**: Darlene Prettyman moved to approve the Minutes from January 2018; seconded. Motion carried with all Aye votes and C. Treadwell abstaining.

4. Update on WET Five-Year Plan Implementation and Overview of the Process for the Development of the Next Plan

John Madriz and Stacie Walker of the Healthcare Workforce Development Division, Office of Statewide Health Planning and Development (OSHPD), gave the presentation.

Ms. Walker stated that they were going to share what they have learned through some of the research studies funded by the 2014-19 Workforce Education and Training (WET) Five-Year Plan. They were also going to discuss WET's current programs and share plans for the development of the next Five-Year Plan.

- As part of the current Five-Year Plan, OSHPD contracted with Resource Development Associates to analyze the impact of mental health policy changes from 2008-15.
    - The Affordable Care Act greatly increased the number of insured individuals in California.

    - The insurance change increased private health plan demand for behavioral health care providers, drawing many of them away from the public mental health system.
    - The 2011 public safety realignment also had a direct impact on the public mental health system, increasing demand because of the number of people being released from the correctional system, but also because this population tends to have higher behavioral health needs.
- Mental illness prevalence has been around 18% and Serious Mental Illness (SMI) has been around 4%. Youth with Serious Emotional Disturbance (SED) has been around 7.5%.
- Since 2008, access to Medi-Cal has nearly doubled. The provider population has done the same.
- Despite the growth in workforce, the public mental health system is barely keeping up with service needs.

Ms. Walker discussed county WET activities.

- As part of the Five-Year Plan, OSHPD engaged a contractor to conduct a review of the county WET programs. The data Ms. Walker presented was given in broad generalities. Data was given voluntarily by 58% of the counties.
    - On average, counties with large populations spent 86% of available funds; medium counties spent 78%, and small counties spent 82%.
    - 42% of large counties spent all of their WET funds; 40% of medium counties, and 53% of small counties spent all of their funds.
    - Large counties spent the largest portion of their funding on financial incentives designed to grow the workforce. Small and medium counties plan spent the largest portion of their funding on workforce and staffing support, and on training and technical assistance.
    - All counties reported that growing their workforce was their most pressing issue.
    - Other pressing challenges were insufficient resources and funding; staff shortages and high turnover; bureaucratic barriers; and a lack of evaluation activities across the board.

Mr. Madriz highlighted the WET activities during the first three years of the current Five-Year Plan.

- The Education Capacity Program has been responsible for training an additional 135 clinical psychiatrist residents and 138 psychiatric mental health nurse practitioners.
- The Recruitment and Career Awareness Program has exposed 26,000 students to mental health careers and has provided 90 students with internships in the public mental health system.

- The Stipend Program has awarded over 950 stipends.
- The Mental Health Loan Assumption Program (MLAP) has supported over 8,000 mental health professionals by providing up to $10,000 in loan repayments in exchange for working 12 months in the public mental health system.
- The Peer Personnel and Preparation Program has supported the training and placement of more than 1,300 people with lived experience in the public mental health system.
- The Consumer and Family Member Program has supported training sessions for people with lived experience, as well as for employers who may hire people with lived experience.
- Regional partnerships have supported regional coordination of numerous strategic initiatives designed to increase the capacity of the public mental health system.
- Approximately two-thirds of participants in the state WET programs are from underrepresented minority groups. Just over half speak another language in addition to English.

Ms. Walker explained the *MHSA Workforce Education and Training Logic Model*, used for research and evaluation. It maps the goals set in all the different programs.

OSHPD is engaging in three primary activities to inform the next Five-Year Plan:

1. Facilitate stakeholder engagement from a variety of groups.
2. Conduct an evaluation of the current state WET programs.
3. Conduct a Workforce Needs Assessment of the public mental health workforce.

OSHPD will begin working extensively with a subcommittee of the Planning Council to receive guidance on the focus of the interviews and the planning of the surveys that they will administer to inform the next Five-Year Plan.

Ms. Walker reviewed the short-term timeline for development of the next Five-Year Plan. OSHPD will return to the Planning Council in June to get input on the public mental health workforce.

She stated that OSHPD will post the document *Mental Health Services Act Workforce Employment and Training Program*, which summarizes all the components of the plan they are embarking on and gives a timeline.

The Planning Council should be aware of how the plan is proceeding at every step, so that when OSHPD returns in early 2019 for approval, the Planning Council will know what is going to be in it.

There is an advocate proposal before the Legislature during this year's budget cycle, to fund the state WET programs in FY 18-19. If those funds are identified for state programs in the May Revise, it would be a good idea if OSHPD got the Planning Council's approval for any kind of expenditure authority for FY 18-19. This would ensure no break in services.

Questions and Discussion

Ms. Pitts stated that for the last 18 years, she has tried to get the Occupational Therapist position identified as a Mental Health Provider in the State of California. She urged consideration once again from OSHPD to be listed – at least a paragraph which Ms. Pitts could provide.

Ms. Mueller felt that academic training and the institutions in the public sector (community colleges and California state universities) should be looked at as significant stakeholders in the pipeline process. Ms. Walker agreed that the back end is very important.

Ms. Mueller asked whether Nurse Practitioners would fall into the category of Prescribers or of Non-Prescribers. Ms. Walker responded that page 4 of the RDA report contains the categorizations of the specific disciplines.

Ms. Tucker commented that one of the slides showed an ethnic breakdown of only White and Hispanic. What about the Native American and Black communities? Mr. Madriz answered that they have that data also and are having a tabulation completed by UCSF on the first two years for a more thorough breakdown.

Ms. Tucker noted that across the nation, it is extremely hard for people of color to find counselors and psychiatrists who look like them. Mr. Madriz stated that one of the goals of their programs is to ensure more diversity in recruitment, training, and placement. Outreach efforts encourage people from diverse backgrounds to apply for stipends and loan repayment programs. Ms. Tucker suggested trying new ideas around recruitment. Ms. Walker agreed, and stated that Planning Council members who work in the community probably have much better ideas than the OSHPD staff.

Mr. Leoni described the dilemma of figuring out how to get long-term money on an ongoing basis for the WET program after the end of the current Five-Year Plan. What is really needed is not another Five-Year Plan, but a restructuring for the future so we can pitch something to the Legislature. He also noted the innovative programs in progress at the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the individual counties; some innovations may demand different mixes of service providers. Ms. Walker replied that she couldn't agree more. She felt that projections done based on the past are helpful in spurring change.

Mr. O'Neill asked about the 26,000 students in Career Development that have been exposed to Behavioral Health careers. At what age does the exposure start? Mr. Madriz responded that the majority of the grants are for high schools but they also include adult education.

Mr. O'Neill noted that the 2016 Data Notebook had focused on youth; for penetration rates broken down for youth aged 5-20 years, racial demographics show that the highest penetration rates are for white youth. This is probably because white youth are receiving services from white providers. It is critical that the WET program gets out into all communities, especially those of color, so that those young adolescents may be inspired to go into this field. Mr. Madriz stated that some of the organizations that have been

awarded grants, as well as the newly-established Pipeline program, are focused primarily on underrepresented communities.

Ms. Lee asked if the large counties have a time limit to spend their funding. Ms. Walker answered that there are time parameters around how long counties have to spend the funds; if unspent, the funds revert back to the state. Executive Officer Adcock said that counties have 10 years to spend their WET dollars, which will conclude this June.

In answer to a question from Ms. Lee, Mr. Madriz described the stipend programs. They are set up for four disciplines: social workers, psychiatric nurses, marriage and family therapists, and clinical psychologists. The first three are funded at $18,500 while the last is $20,000. The funds are used to help the students finish their education; in addition to the stipend, they receive training and support. They sign an agreement to start working in the public mental health system within six months; they must work for 12 months.

Ms. Prettyman supported Ms. Pitts' statements about the value of Occupational Therapists in mental health services.

Ms. Kelley stated that the MHSOAC data is not the best place to get information. It may look like counties are not spending, but in her county of San Bernardino, for example, they spent all of their WET funds in 2014 and proceeded to continue to fund their WET programs through Community Support Services.

Ms. Moore reiterated the plea to include Occupational Therapists. If you do not get the occupational capabilities taken care of first, the individual will not be ready for vocational. One may enter into a never-ending cycle.

Ms. Mowers-Moore asked for clarification on spending of the funds. Ms. Walker explained that there were county WET funds that OSHPD was not a part of. The evaluation looked at how counties were spending those funds. Part of the state WET Five-Year Plan included evaluation funds to look at how the counties used their local WET funds. Ms. Walker wanted to share some of the survey data with the Planning Council. In prioritizing how the money was spent, the small and mid-range counties had spent more on training while the large counties spent more on financial incentives.

Ms. Oseguera asked if OSHPD was looking to improve evaluation of how WET funding is being used, and whether any improvements are being considered if funding is granted for next year. Ms. Walker replied that it must be advocates who request more funding for the program rather than OSHPD. If the funds are approved, OSHPD will come to the Planning Council to ask if they want to retain that funding or change it.

Ms. Oseguera asked about seeing if funding can be allocated elsewhere (safety nets, non-profit providers) for counties that are not using it. She asked about evaluation of how funds are being used. Ms. Walker replied that Dr. Toby Ewing, Executive Director of the MHSOAC, would be the more appropriate person to respond to questions about how WET funds that revert can be used.

5. Public Comment

Mandy Taylor, California LGBT Health and Human Services Network, encouraged OSHPD to look at people with intersecting identity (for example, black and LGBT) as

they recruit people into the WET programs. She pointed out that the transgender community has one of the highest rates of suicide, both completed and ideated. The statistics show that when transgender people get access to medically appropriate care, the suicidality decreases dramatically. Ms. Taylor added that the Out for Mental Health program is funded through the MHSOAC as a part of the stakeholder contract process. When WET does their stakeholder process, Ms. Taylor encouraged them to reach out to the stakeholder contractors.

Theresa Comstock, California Association of Local Behavioral Health Boards and Commissions (CALBHBC), stated that they will be present at the Planning Council June meeting to provide stakeholder input.

Ms. Lee mentioned Landmark, a physician assistant program working out of Medi-Cal and Medicare, whose primary purpose is to keep people in their homes.

6. Council Training: Implicit Bias

Lestford Duncan, Cultural Competency Officer with the San Bernardino County Department of Behavioral Health, gave the presentation. By way of preface he noted the shared ground rules that this is a difficult topic, but we should show professional respect among ourselves; and we should all keep an open mind to understand each other.

- In San Bernardino County Behavioral Health, the Office of Cultural Competence and Ethnic Services is responsible for ensuring health equity across our system of care.
- Mr. Duncan led the Planning Council members in an activity in which they introduced themselves and named the cultures by which they identify.
- Mr. Duncan noted that when we do not really know each others' backgrounds, cultures, and experiences, it can make it difficult to work together and hinders the work we could do. His office encourages people to bring their whole selves to their work.
- Part of cultural competence is finding commonalities as well as recognizing and respecting differences, which do not necessarily need to divide us.
- We define culture as *any group that shares beliefs, values, or norms*. Mr. Duncan challenged the members to think of culture more broadly than just race and ethnicity.
- Culturally competent mental health care systems are *systems that embrace a set of congruent behaviors, attitudes, and policies that come together within that system, agency, or among professionals and enable that system to work effectively in cross-cultural situations*.
- Race is a social construct – not tied to any particular geography or genetics. There are five main racial categories as defined by the national census:
    - Asian/Pacific Islander
    - Caucasian or White

    - Hispanic/Latino
    - African-American
    - Native American
- Ethnicity is a better indicator of the geography or heritage of an individual – it comes closer to the culture.
- People identify with various other subcultures: LGBTQ, gender group, age or generational groups, spirituality or religious groups, status of recovery, veteran, socioeconomic status, and ability.
- Services are not effective if they are not culturally competent or culturally relevant.
- Mr. Duncan showed a brief video illustrating why cultural competence is important via an interaction between two strangers.
- Cultural competence starts when we address the consumers who are accessing our services; at the front desk with the first interaction; with law enforcement; at the Board Room table; at the Executive Team level; and in conversations with planning services for the consumer.
- Diversity is more than just having a rainbow of different faces at the table. It is diversity of thought and opinion, and asking if everyone at the table has an equal voice.
- Cultural competence starts at an individual level.
- Mr. Duncan addressed implicit bias. It takes into consideration your views and opinions on a person's ability, gender, socioeconomic status, sexual orientation, marital status, appearance, ethnicity, race, culture, educational level, religion, etc. He showed a short video.
- Implicit bias is brought up in the media in relation to recent police shootings of unarmed black men. Law enforcement officers experience a quick association that results in them making a snap judgment on whether or not to pull the trigger.
- Mr. Duncan paired up the Planning Council members. They described to each other an early life experience where they felt a sense of "otherness" – they recognized that they were different. Two members then shared their partner's experience.
- Mr. Duncan explained that implicit bias results from our tendency or need to classify individuals, objects, and experiences into categories. It is biological – how our brain wires itself for survival purposes.
- We have to consider the way we were brought up and the messages put on us at a young age. Biases are natural; associations are made very quickly especially after repeated events. However, we need to bring it to our consciousness and address it. Mr. Duncan shared an experience of bias from his youth in Jamaica, that

changed when he grew up and became more familiar with that group of people – intentionally addressing his bias.

Mr. Duncan and Planning Council members continued to share personal stories of implicit bias.

- Mr. Duncan described explicit bias: thoughts, attitudes or prejudices in our conscious minds that we act upon, both positively and negatively. It can manifest itself in racism, racist behavior, and racist comments.
- Mr. Duncan encouraged the Planning Council members to take the Harvard Implicit Association Test, a powerful tool that allows you to look at your bias and preference in a number of different categories.
- "Cousins" of implicit bias are:
    - Affinity bias: Naturally giving preference to people or ideas that are similar to ourselves. It makes us feel comfortable.
    - Confirmation bias: Seeking out or looking for behaviors that confirm what we believe to be true. Social media tools have algorithms that tend to present us with things that we like (politics, food, dating, etc.). This isolates us from understanding how other people feel and believe.
    - Attribution bias: attributing our own success or good fortune to merit, while our failure is due to external factors. For other people, we attribute their success to luck, while their failure is due to personality or bad habits.
- Implicit bias is also associated with micro-aggressions: acts that occur unconsciously from implicit or explicit bias. They are subtle but stunning in that they can take a person off-guard. They are automatic. An example is assuming that a person who speaks another language is hard of hearing, so you speak louder to get your point across.
    - Micro-assaults are explicit, direct, derogatory statements.
    - Micro-insults are unconscious communications that demean a person from a minority group.
    - Micro-invalidations minimalize or lessen a person's experience. The message is, "You shouldn't feel the way you feel." However, in behavioral health we recognize that a person's experience is their reality.
- In the workplace, we should address micro-aggressions by calling them out in a calm and clear manner rather than avoiding the situation. Model appropriate behavior for your staff or team, as well as friends or peers. Focus on the incident, not the individual.
- Our goal is to foster a greater level of understanding between cultures and communities.

- On an individual level, we emulate cultural proficiency by raising awareness, by accepting others' differences, by having an awareness of our own cultural values as well as our biases.
- Mr. Duncan encouraged the Planning Council to lean in to conversations in the workplace about diversity and culture – to understand the dynamics of the differences.
- He encouraged the Planning Council members to develop cultural knowledge and to take on the opportunity to learn and understand other cultures. He challenged them to put themselves in uncomfortable situations with people they do not know or understand.
- He encouraged them to adapt diversity and cultural competency into their policies, practices and procedures.

7. Public Comment

There was no public comment.

Chairperson Mitry recesssed the meeting at 5:05 p.m.

Thursday, April 19, 2018

1. Welcome and Introductions

Chairperson Mitry opened the session. The Planning Council members introduced themselves.

2. Council Member Discussion of Proposed Council Priorities

Chairperson Mitry noted that the packets contained excellent information on CBHPC priorities and committee descriptions.

He opened the meeting by reading the Council's Mission Statement. The CBHPC reviews the behavioral health system for accessible and effective care; it advocates for an accountable system of responsive services that are strength-based, recovery-oriented, culturally competent, and cost-effective. The CBHPC educates the general public, the behavioral health constituency, the stakeholders, and Legislators.

Mr. Leoni requested Executive Officer Adcock to go over the topics she had shared earlier with the Advocacy Committee. She explained that staff had looked at the existing committee workplans and mapped the items to the proposed committees. There are still overlapping subject areas about which the committees could decide. Ad Hoc committees will have meeting space and meet late Wednesday mornings for 1½ - 2 hours; whether

they will be staffed is still undecided. It may be necessary for Ad Hoc participants sometimes to travel on Tuesday evenings depending on meeting venue and transportation schedules.

Ms. Mueller asked if there had been any dissension over this proposal. Executive Officer Adcock responded that from the January discussion, members had felt strongly that three key areas would have been lost; that is why the Ad Hocs were created.

Ms. Nepomuceno requested to have students in general education included in the Systems and Medicaid area of priority. Executive Officer Adcock responded that at the June meeting, the committees will meet and write their charters.

Ms. Hart referred to the block grant: she assumed that the Block Grant Ad Hoc committee is dissolved. She asked if housing and homelessness will address the needs of youth as we go along. Executive Officer Adcock confirmed that it would.

Mr. Leoni introduced an idea for a recovery/resilience/wellness caucus. The recovery concept is under assault right now in different levels of government and media. Chairperson Mitry responded that this concept had been recognized as one of the principles to guide each committee.

Ms. Mitchell requested Executive Officer Adcock to review the proposed meeting schedule. She responded as follows:

- Executive Committee: Wednesday 8:30 – 10:15
- Patients' Rights Committee and ad hoc groups: Wednesday 10:30 – 12:15
- Two of the committees: Wednesday afternoon
- The other two committees: Thursday morning
- General Session: Thursday afternoon and Friday morning

Ms. Wimberley commented regarding the Medicaid and Systems priority: she suspected that there will be block grant areas other than the Substance Abuse & Mental Health (SAMHSA's) First Episode Psychosis funds that will be woven in as the committee develops. Ms. Wimberley also commented that within Housing and Homelessness there are some adult and older adult types of services that will overlap here as well.

Ms. Lee commented that substance abuse seems to be left out.

Mr. Leoni pointed out the one remaining piece to be decided in these changes: of the four committees other than Patients' Rights, if Planning Council members are interested in two that are scheduled to meet at the same time, the members will have to give one up.

3. Public Comment

Ms. Comstock of CALBHBC requested that the meeting schedule for committees be posted on the website as soon as possible.

4. Council Vote: Executive Committee Motion

Motion: Darlene Prettyman moved to approve the Planning Council's focus on five areas of priority and committees: Patients' Rights, Housing and

Homelessness, Systems and Medicaid, Workforce, and Advocacy/Legislation. The Council will continue with ongoing activity and attention on the following: the SAMHSA Mental Health Block Grant, Children and Youth, Performance Outcome Review, and Reducing Disparities. Seconded by Robert Blackford. Motion carried unanimously.

5. Mental Health Block Grant Overview

Executive Officer Adcock provided a historical perspective on why Planning Councils were created.

- The federal government created the Mental Health Block Grant (MHBG) for states to facilitate the deinstitutionalization of the 1980's. Planning Councils were established to help oversee and ensure that states were developing comprehensive mental health plans to address the areas lined out by the federal government. Any state that accepted the block grant was required to have a Planning Council.
- Planning Councils were charged with participating in the development of the plans, as well as reviewing and commenting on the ultimate plan.
- The federal government gives three mandates to Planning Councils.
- The Planning Council Mission and Vision statements look at the entire system, holding it accountable for accessibility and effectiveness.

Ms. Wimberley, who is the MHBG Planner for the State of California, gave an overview of the block grant.

- She gave a brief history of the development leading to the block grant. In 2011, Realignment in state government shifted community mental health, and the MHBG program to the Department of Health Care Services (DHCS).
- The MHBG application includes two distinct parts: a Biannual State Plan (due every two years in September) and an Annual Implementation Report (due each December).
    - The Biannual State Plan must include sections on State Information, a Planning Steps narrative, Planning tables, and Environmental Factors and Plan.
    - The Implementation Report describes the extent to which the State implemented its mental health plan for the prior year. It consists mainly of tables of demographic data.
- According to Section 1912(b) of the Public Health Act, states must address five criteria in their mental health plans:
    - Comprehensive Community-Based Mental Health Services Systems
    - Mental Health System Data Epidemiology
    - Children's Services

    - Targeted Services to Rural and Homeless Populations and to Older Adults
    - Management Systems
- The state has 24 months to expend the MHBG funds.
- For the current state fiscal year, California's MHBG award is $74,183,108.
- The counties receive $49 million as a base allocation within its reimbursable amount. The rest of the MHBG funding breakdown includes the Children's System of Care projects, Dual Diagnosis projects, First Episode Psychosis set-aside programs, Integrated Service Agency programs, and administrative support costs.
- The populations to be served with MHBG funds are children diagnosed with a serious emotional disturbance and adults with a serious mental illness.
- Block grant dollars serve as a flexible fund source for the local level. However, they cannot be used to provide inpatient services, to make cash payments to intended recipients, to purchase or improve land/facilities nor major medical equipment, to satisfy requirements for the expenditure of non-federal funds as a condition for the receipt of federal funds, or to provide financial assistance to entities other than public or nonprofit private.
- The California Mental Health Planning Council (the title the federal government still uses) is required to do the following:
    - Review and comment on the state MHBG Plan and Implementation Report.
    - Advocate for persons with serious mental illness and children with serious emotional disturbance.
    - Monitor, review, and evaluate, at least yearly, the allocation and adequacy of mental health services in the state.

Another requirement of the block grant is peer reviews (which Ms. Wimberley terms "program performance reviews"). In the past, DHCS has asked CMHPC to participate in peer site reviews as a member of its team. There is a specific emphasis to facilitate the client focus groups. Ms. Wimberley is attempting to acquire more staff to manage the block grant and to work on the site review team.

Questions and Discussion

Ms. Lee asked about completing the plan in terms of the dollars requested. Ms. Wimberley replied that when they complete the plan, they have to include estimated figures. However when the new President took office, the chance arose that the block grant dollars would be decreased to $54 million from $74 million. The plan stipulated that if this happens, the DHCS will have to examine the feasibility of applying for the block grant. Fortunately, SAMHSA has now notified Ms. Wimberley that an increase has been indicated for FY18 to $94 million.

Ms. Mitchell asked about any mandates or prioritizations that have changed for SAMHSA. Ms. Wimberley replied that she is siloed to the block grant; First Episode Psychosis seems to be currently the most important to SAMHSA. Executive Officer Adcock added that one year, it was Trauma-Informed Care. They do periodically change their focus which results in major written changes to the plans. Ms. Wimberley added that monitoring and oversight of the program – documenting its integrity – are constantly on SAMHSA's radar.

Ms. Rangel asked about the $2 million given to two counties for Integrated Services Awards. Ms. Wimberley answered that Los Angeles and Stanislaus Counties received $1 million each for Integrated Services for Adults and Older Adults.

Mr. O'Neill asked who pays the Maintenance of Effort (MOE) for the mental health side. Executive Officer Adcock answered that state dollars from Realignment pay for that. Mr. O'Neill then asked if there will be new First Episode Psychosis programs in response to the bump in funding, or if the $20 million will be distributed to counties with the existing programs. Ms. Wimberley responded that in accordance with the state statute, any increase or decrease to the block grant must be distributed among the counties equitably per a formula.

Mr. Leoni commented that during his years on the Planning Council, he has never seen the State Block Grant Plan or Implementation Report. He asked about how funding is awarded to programs in specific counties. Ms. Wimberley explained how funding for the Children's System of Care was awarded to the seven counties to continue their programs already in place. Mr. Leoni then asked about the process for awarding money to one county but not another in particular categories. Ms. Wimberley replied that distribution of funding and percentages has been based on historical information and types of formulas. She offered to assemble some information that her office can submit to the Planning Council staff for dissemination.

Ms. Hart noted that the Planning Council has been involved in the MHBG process – due dates for the documents have not corresponded with the timing of the Planning Council's October meeting. Executive Officer Adcock added that the Executive Committee has recognized the need to be more knowledgeable about the MHBG. We are invested in spending some amount of time in every meeting talking about an aspect of the block grant, to better equip all of us to provide more relevant and valuable input.

Theresa Comstock reported that in Napa County, every year their Mental Health Board looks at a SAMHSA grant application. Is that the same as this block grant? Ms. Wimberley replied that Napa does participate and receives block grant dollars for which the County submits their plan to use the funds. The presentation had been about the state's plan that they must submit to SAMHSA to receive the block grant dollars, to be allocated to the local level in turn.

Ms. Comstock then noted that Public Comment must be attached to the submitted State plan. Ms. Wimberley stated that there are various ways that her office can do Public Comment, including online via the webpage and conference calls (which had been done this year).

Ms. Rangel asked about the site reviews. Ms. Wimberley answered that first the county submits some information that ensures that they are spending the dollars in accordance with state and federal regulations. Her office then goes out to look at county programs. There is also a component where the participating Planning Council member conducts a client focus group.

Public Comment

Ms. Taylor asked if the block grant is considered part of Medicaid/Medicare or a different pot of money. Ms. Wimberley replied that the block grant dollars fill in the gaps in service – it funds services not covered under Medi-Cal.

6. Panel of Bay Area Counties Re: Programs and Use of Mental Health Block Grant Funds

Kavoos Ghanebassiri, Mental Health Director for the City and County of San Francisco, and Director of Behavioral Health Services within the Department of Public Health; and Jei Africa, PsyD., Behavioral Health Director for Marin County, began by providing their backgrounds.

Mr. Ghanebassiri spoke about the distribution of SAMHSA block grant funds across the system of care in San Francisco.

- 60% goes to community-based organizations, 40% to the civil service system. The total budget is about $5 million.
- The block grant is currently about $3.8 million. Mr. Ghanebassiri explained where the funding goes.
    - **Adult and Older Adult Systems of Care**. The 24/7 behavioral health access team, the transitions/placement team, and peer support services (at clinics and Pathways to Discovery, a peer wellness center).
    - **Cultural Competence**. Health workers, health educators, administrative support, and social work clinical support.
    - **Quality Management**. Education and training for documentation and compliance.
    - **Children's Services**. The Family Mosaic project, which is wraparound support for children.
    - **First Episode Psychosis**. It is contracted through Family Service Agency, currently called Felton Institute.
    - **Dual Diagnosis Programming.** Funding involves getting the services embedded within the community and paying for the professionals.
- All of the programs except the peer-focused empowerment project and the peer wellness center are also funded through other sources. This is the ideal scenario: to have programs diversified so that they are sustained through multiple support resources.

Dr. Africa spoke about efforts in Marin County.

- About 2,000-2,500 clients are served.
- Behavioral Health is under Health & Human Services. The total budget is about $61 million.
- Marin County is affluent, but when you look at the data, disparity is evident between the white community and the Latino/other minority community.
- The block grants are spent focused on wellness and recovery, and enhancing cultural responsiveness. The block grants also fund programmatic support for existing programs (clinical support, client support, having peers and family partners as part of service delivery).
- The block grant is about $630K and serves 150-200 people. It funds enhancement with the children's system of care, dual diagnosis, and first episode psychosis.
- The county has a contracted Homeward Bound-Voyager program.
- A licensed Latino mental health practitioner, a family partner, and a youth coach are funded.
- 24-hour residential care is funded for people with a serious mental illness who have co-occurring disorders.

Questions and Discussion

Ms. Lee asked if any money is appropriated for the jails. Mr. Ghanebassiri answered that Behavioral Health Services and Jail Health Services are two different sections within the Department of Public Health. Dr. Africa answered that either Homeward Bound or Buckelew targets people coming out of the criminal justice system in Marin County.

Ms. Rangel asked about specific programs through this grant to assist those coming out of prison who are re-entering the community. Dr. Africa answered that in Marin County the Star Full Service Partnership program (not funded by the block grants) provides wraparound service for those coming out of the jail system. Mr. Ghanebassiri answered that re-entry, behavioral health court, drug court, and the community justice center are available (although not specifically supported by this block grant). Transitions is one team for people who are being referred for placement.

The speakers confirmed for Ms. Wimberley that there are partnerships going on for the consumer. She asked about Family Mosaic. Mr. Ghanebassiri responded that it had at first consisted of both civil service staff and contracted staff; now staff is fully under civil service. He and Dr. Africa confirmed that the block grant helps to fund the gaps left by Medi-Cal and MHSA.

Ms. Hunter asked which age groups are served by the Peer Wellness Center. Mr. Ghanebassiri responded that it is for 18 years and older. The program offers drop-ins and various forms of social engagement. Over 900 people are active members. They can be consumers of any behavioral health services in the city.

Ms. Lee asked Dr. Africa if they do any type of work in San Quentin. He responded that San Quentin prison is a different system; his system works with the local jail. Ms.

Rangel stated that Marin County does not but San Francisco County does serve San Quentin with the Transitions program.

Ms. Lee asked if they have anything to do with the 51-50's; they replied that they do not.

Ms. Hart stated that when the Planning Council was helping out with the Peer Reviews, they did go to the jails. The allocations and the counties may differ with time.

Mr. Leoni asked about the sustainability of the programs should the block grant go away. Mr. Ghanebassiri replied that all of the programs would continue, possibly with slightly decreased staffing. San Francisco is averse to starting programs that cannot be sustained without the block grant. Dr. Africa stated that two of Marin's block grant programs are essentially enhancements to existing programs. Mr. Ghanebassiri added that San Francisco is commitment-driven rather than funding-driven, unless it is innovation funding which is for learning.

Ms. Wilson asked the percentage of their budget that is SAMHSA block grant money. Mr. Ghanebassiri answered that the block grant money is $3.8 million while the budget of direct behavioral health is $570 million. Dr. Africa answered that the total behavioral health budget is $61 million while the block grant is $633,000.

Mr. Ghanebassiri pointed out the creativity aspect in the programs, such as the empowerment services; and the cultural enhancement and support which allows for effective practice.

Dr. Africa stated that it is important to understand the parameters of being a public servant using public dollars. He asked for the support and feedback of the Planning Council. He himself is inherently committed to the role of people with lived experience in our system. He also knows the importance of changing the infrastructure to avoid spinning our wheels. It is not a privilege, but a right, to be healthy in this state.

Chairperson Mitry brought up the population of underserved groups and those who are hard to reach and engage because they are hard to identify, such as older adults. What is the outreach strategy for these groups? Mr. Ghanebassiri responded that the county employs perspectives of being trauma-informed, "any door is the right door," and "whatever it takes." The people who come to them and are engaged with them do very well in the robust, strong system. The challenging part is the ones who don't know about them or are not coming to them. Mr. Ghanebassiri looks at the system end: what are they not offering; what are they doing to not engage? There needs to be opportunities in the community that are not treatment-based. We need to recognize the embedded nature of distrust and disconnect. The block grant can and should be used for those kinds of challenges.

Dr. Africa responded to Chairperson Mitry by asking how we engage; does the staff represent the community? 65% of county employees cannot afford to live in Marin County; thus they may not understand the community. When staff must travel two hours one way to get to work, can they provide the best care? In Marin they are engaging the faith-based community to understand wellness and recovery.

Ms. Lee asked if they thought the state hospitals would reopen to address the homeless situation. Mr. Ghanebassiri stated that they are trying to tackle the homeless problem with a multi-pronged approach. They have opened a facility for people who have homelessness and mental health issues – a partnership between St. Mary's, Dignity Health, UCSF, and the Department of Public Health. One of the Supervisors is trying to pass legislation to prioritize housing for individuals with behavioral health issues. The new Department of Homelessness and Supportive Housing used to be embedded in the Department of Public Health. The biggest challenge is transitioning people from one facility or program to the next.

Announcements

Executive Officer Adcock requested Planning Council members to come to the Capitol on May 23 to participate in Mental Health Matters Day. Ms. Nepomuceno stated that also on May 23, local events will be happening statewide – 15 high schools will be presenting events through mini-grants from Each Mind Matters.

Ms. Tucker stated that on March 16 she had attended the first MHSOAC-initiated committee meeting on suicide and suicide prevention. She reviewed the event.

- Shasta County has the highest suicide rate in the state. More than half of the suicides were done with firearms. The committee had discussed the reason rural counties have higher suicide rates than urban.
- As most of the suicides are men, Shasta County is trying to reach men using approaches germane to them.
- Veterans feel very reluctant to ask anyone to help them when they come home and try to adjust.

Ms. Tucker stated that any CBHPC efforts to pursue suicide prevention could benefit from accessing the work done by this MHSOAC Suicide Prevention Committee.

She explained the Honor Beads she wears indicate that she has survived her own suicide attempts. She distributed an article on suicide prevention that is helping her personally.

Executive Officer Adcock stated that the MHSOAC has been tasked with developing a statewide suicide prevention plan. They will be holding further stakeholder meetings.

Ms. Tucker explained Safe Black Space, a community healing circle for people of African descent to promote community and personal healing around the violent treatment of that community.

7. Committee Reports – Evaluation & Quality Improvement, Health Care Integration, Patients' Rights and Advocacy

<u>Evaluation & Quality Improvement Committee</u>

Walter Shwe, Committee Chair, gave the report.

- The 2016 Data Notebook Report is almost in its final form.

- The Felton Institute gave a presentation. They run programs in San Mateo County in Prevention/Recovery and Early Psychosis, and Bipolar Disorder Early Assessment and Management.
- The committee looked at a draft white paper on First Episode Psychosis.
- They discussed the next Data Notebook. They will hire a consultant to help Linda Dickerson and to help the committee do the actual research that goes into the Data Notebook. They will divide it into two sections: Performance Indicators and questions on a particular topic for the year.

Health Care Integration Committee

Liz Oseguera gave the report.

- Santa Clara County and San Mateo County gave presentations on their Whole Person Care programs.
- San Benito County spoke about how they are integrating their services.
- The County Behavioral Health Directors Association spoke about the Medicaid 2020 cliff.
- At the previous committee meeting, they had ensured that their work will be followed up in other committees because they are going to be dissolved.

Patients' Rights Committee

Daphne Shaw, Committee Chairperson, gave the report.

- The committee is working on two legislative bills. More detail will be presented on Friday morning.
- The committee discussed where they will go next: patients' rights issues at the state hospitals versus county jails. They took a vote and decided to pursue patients' rights issues around county jails – with that population, more clients will be impacted than the state hospitals.

Advocacy Committee

Darlene Prettyman, Committee Chair-Elect, gave the report.

- They discussed the support bills. Executive Officer Adcock reported that the committee had taken a position on about a dozen bills; now they will go back and work on the letters to the authors.
- Vic Ojakian gave a presentation on suicide and the bills he is presenting for training for clinicians. The committee decided to support the bills he is sponsoring.
- Executive Officer Adcock gave an update on the adult residential facility. Next step is to hold a Summit to discuss proposed solution.
- The committee discussed their workplan, deferring it until June when new members join the committee.

- They discussed the CBHPC priorities and voted unanimously to support the Crosswalk.

Ms. Flores stated that Cisco has donated $50 million to help the homeless in Santa Clara County over a five-year period. In her travels, she has observed an increase in the number of homeless in California cities.

Ms. Mitchell announced that Interim Inc. is opening a new residential treatment program on May 11 for people who are dually diagnosed. They have also built a facility for a day treatment program at a different location on the site. They have 32 beds of transitional housing and 28 beds of permanent housing on an approximately five-acre site. In addition they own 20 apartments two blocks away.

8. Public Comment

Barbara Weisman from San Mateo County, a former Planning Council member, stated that she does home visits to elderly patients. She would be happy to give a presentation on her work.

Ms. Wilson reported that Walter Shwe had been recognized at the Pat Williams Mental Health Dinner in Davis as the Advocate of the Year.

Motion: Raja Mitry moved to recess the meeting; seconded by Susan Wilson.

Friday, April 20, 2018

1. Welcome and Introductions

Chairperson Mitry opened the meeting and expressed appreciation for everyone's presence. The Planning Council members introduced themselves.

In order to remind everyone as the CBHPC convenes the quarterly meetings, Chairperson Mitry shared the CBHPC Vision Statement and Mission Statement.

2. Report from the California Association of Local Behavioral Health Boards/Commissions

Teresa Comstock, CALBHBC President, reintroduced the work and current issues of CALBHBC, as well as what they need from the Planning Council.

- CALBHBC is made up of all 59 Mental Health Boards and Commissions around California.

- Ms. Comstock referred the Planning Council members to the back of the CALMBHBC quarterly newsletter, which lists its eight duties. The Board members have the responsibility to advise the Behavioral Health Director and the Board of Supervisors.
    - They should be doing site visits and even looking at fiscal information.
    - CALBHBC supports them and shares resources, supplying training materials, handbooks, and online materials.
    - They need to identify and understand the needs in their communities.
- CALBHBC has five regional meetings per year. They do conference calls every other month.
- The number one issue is always housing.
- This year, the issue of disaster readiness and recovery has come to the forefront. Right after a disaster comes a surge in need for mental health services, and the need continues for those who have been traumatized at all age levels.
- The current newsletter focuses on employment: the practice called Individual Placement and Support which has been a success, as well as Peer Provider Certification and SB 906.
- Ms. Comstock suggested that the Planning Council advise CALBHBC on the materials going into their newsletter, collaborate on devising CALBHBC's Friday schedule, and assist in the coordination of training and information for CALBHBC.

Questions and Comments

Ms. Prettyman noted that some of the Mental Health Board members in her county do not know how to read the plans that go to the Board of Supervisors. Her Mental Health Board is dividing the plan into sections, and the members each decide where they want to be in readings. They meet beforehand to go over it, then present it to the Board of Supervisors. Ms. Comstock agreed that breaking down the plans is the best way to go over them.

Mr. Leoni suggested using modules of best or promising practices for Mental Health Boards and Commissions to function. If this were available for people to look up, it would be a good resource. Ms. Comstock noted that they have developed a handbook called Best Practices which they keep supplementing; they have a few pages now on how to look at the MHSA.

Ms. Wilson noted that the Planning Council has a liaison to CALBHBC; they do maintain a great relationship that has evolved over the past several years. Last year the Planning Council invested $25,000 in a project from which the CALBHBC developed a business plan.

Ms. Hart congratulated CALBHBC in doing a fabulous job of getting out into the counties – this has made a tremendous difference in integrating more people into the process, as well as training.

3. Adult Residential Facility Issue Brief and Next Steps

Ms. Prettyman stated that the Advocacy Committee had been working on the housing issue and had developed a white paper on Adult Residential Facilities.

Dorinda Wiseman, CBHPC staff, spoke about the Adult Residential Facility project.

- The project began with the Advocacy Committee starting to look at Institution for Mental Disease (IMD) beds and being unable to find data. The Department of Community Care Licensing had also requested assistance – they were very concerned about the number of facilities that were closing, did not have appropriate programming, or had untrained owners and providers.
- Ms. Wiseman gave the timeline of the developments within the Planning Council.
    1. In October 2016 and early 2017 the Advocacy Committee had draft paper discussions.
    2. In April 2017, Santa Clara County provided a panel that described their efforts to financially supplement their providers, as well as their work with county government entities.
    3. In October 2017, representatives from the Cash Assistance Program, the SSI/SSP program, and Community Care Licensing of the Department of Social Services discussed the Department's responsibilities and roles.
    4. Stakeholder meetings to discuss the White Paper were held in San Bernardino County and Yolo County which some Planning Council members attended.
    5. There was a statewide conference call in March to review the final draft of the white paper.
    6. There is great interest across the state in mimicking the system within the Developmental Disabilities sector, in that there are different levels depending on the individual's need; the individual is assessed, and the supplemental payment is attached to that level.
    7. The projection at this point is to hold discussions with the Department of Social Services to look at medication storage issues, age constraints, dual diagnosis constraints and conflicts, barriers for persons with lived experiences (with criminal background) not able to work as peers, data acquisition, and formal establishment of a statewide association of best practices.
    8. Several state departments are interested in participating in a Summit.

Ms. Prettyman noted that many people are being housed in residential facilities and cannot get out – there is no place close to their families where they can go. Facilities are closing right and left; one of the main reasons is that they do not get paid enough to be able to provide 24/7 staffing.

Mr. O'Neill agreed that the cost of the residential care facility must be underwritten by the county. SB 82 has done a great job of creating crisis residential, crisis stabilization, and peer respite. Now we have to ask the question of where those consumers go when they leave the crisis residential. There needs to be local capacity. It is far cheaper for counties to have the adult residential facility than to pay for the IMD.

Ms. Prettyman spoke in favor of small four-to-six bed facilities rather than large IMDs.

Ms. Mitchell noted that back at the start, it had been Ms. Comstock who pushed issues in Napa County. Ms. Mitchell emphasized that the Advocacy Committee is looking at alternatives to adult residential facilities; many consumers do not want that type of housing. The Advocacy Committee is also looking at whether licensing regulations can be changed to allow higher levels of support in the housing, specifically around issues of central storage of medication. In reality, supportive housing is substantially less expensive to operate than residential care – you don't have the licensing rules about 24-hour care and supervision.

Mr. Leoni noted that the word "support" is tricky. There is support for daily living for people who don't know how to cook and who need help taking their meds, etc. There is also rehabilitation support. San Francisco has a program that is transitional-residential: Clay Street House is a year-long program that takes people out of IMDs to get them ready for something like supportive housing. The program is Medi-Cal reimbursable.

Ms. Wilson emphasized what Ms. Mitchell said: people are individuals and have their own needs in terms of living arrangements. Ms. Wiseman stated that a point that had come out in San Bernardino was the case management concept – looking at the individual's needs, tracking them, keeping contact.

Ms. Wilson pointed out the " Not In My Back Yard" problem with regard to adult residential facilities. This problem is getting bigger and results from congregating people that others perceive in a stigmatizing way. It bears close scrutiny in the report.

Ms. Wiseman noted that the Planning Council may not get to the legislative component of this within the next year or two, but there may be some regulatory issues that we will deal with. Either way we will still need active Planning Council appointees.

Mr. O'Neill asked about the summit. Ms. Wiseman stated that they hope it will be held sometime between August and the beginning of September.

Mr. O'Neill commented that it can be very important for each resident to have their own bedroom; sometimes a human being just needs to reboot, and that can be hard without privacy.

4. Patients' Rights Advocates Training and Retaliation Protections

Ms. Shaw, Chairperson of the Patients' Rights Committee (PRC), spoke along with Samuel Jain of the California Association of Mental Health Patient Rights Advocates.

- In 2016, the PRC had decided to do a survey of county patient rights advocates, to learn about their duties, and also to determine if there are any issues we need to address. Staff member Tom Orrock put together a survey.

- Ms. Shaw discussed with Gustavo Medina, Legislative Director for Assemblymember Susan Eggman, where the PRC should go from there. One of his suggestions was for Ms. Eggman to request the Legislative Analyst's Office to do a study.
- The PRC sent the survey out in January 2017. 74 Patient Rights Advocates responded (a little over 50% of the advocates out there). New CBHPC staffer Justin Boese, performed an analysis of the data.
- The PRC completed their white paper in October 2017. The committee made recommendations in three areas:
    - Establish a minimum level of staffing for Patient Rights Advocacy services in all counties. Seek legislation requiring specific ratios for Patient Rights Advocates (PRAs), based on the number of acute mental health beds and county populations.
    - The state should mandate standardized PRA training. This could include a certificate-like program and require mentorship for PRAs providing representation in hearings.
    - Seek legislation to provide whistle-blower protections for county contractors in watchdog roles.
- Assemblymember Eggman's office found that the white paper covered all areas they felt were necessary. After discussion with Assemblymember Eggman, Ms. Shaw, Mr. Jain, and Mr. Medina concluded that they could probably deal with the training and retaliation issues, but to take on staffing ratios would not have been wise at that time.
- In January 2018, Assemblymember Eggman committed to carrying AB 2316 and AB 2317. They were introduced in February 2018.

Mr. Jain spoke first about the job of PRAs, then about the bills.

- Welfare and Institutions Code 5520 lays out the duties of PRAs. It is an important role; PRAs ensure that the civil rights of mental health consumers in locked facilities are protected.
- AB 2316 mandates training for county PRAs. There are no specific training requirements now, although there is an organization required to provide this training. In rural counties there is a lot of turnover among PRAs, particularly in part-time positions.

  This bill requires the California Office of Patients' Rights to post training materials online, and requires counties to ensure that their PRAs have reviewed the materials. The certification is sent to the CBHPC Patients' Rights Committee.

  Ms. Shaw noted that they had wanted an actual program to be developed and actual certification to be required; and received pushback on that.

Mr. Jain stated that a Committee Hearing had been held two weeks ago, and the bill passed at 11-0. The bill has moved on to Appropriations and may get onto the Consent Calendar.

- AB 2317 extends already-existing whistleblower protections to independent contractors and contracted entities. About 50% of PRAs are contractors, and part of their regular duties are to monitor and investigate complaints about the entity that they are contracted with.

  The language states that "anyone who receives and investigates complaints" is covered – including professions other than PRAs. Ms. Shaw noted that it had been Assemblymember Eggman's decision to expand AB 2317 beyond PRAs. There has not been much pushback so far.

  Mr. Jain stated that AB 2317 will cover independent police auditors, ombudsman programs, the Office of Clients' Rights, and the California Office of Patients' Rights – a number of critical organizations doing important work.

  Ms. Shaw noted that PRAs across the state are very diverse; there is no requirement for a professional degree. It can be a peer or an attorney.

5. Updates from CA Behavioral Health Director's Association

Ms. Kelley stated that the CBHDA is made up of directors from 58 counties and two cities. At present they spend much time engaging with budget and policy issues. They are tracking over 150 behavioral health bills targeted toward their populations. They have taken official positions on over 30 of them.

CBHDA is cosponsoring AB 2043, the Foster Youth Crisis Response System. It would create a statewide foster youth and caregiver hotline that they can call when in crisis – building on Continuing Care Reform.

AB 2328, Youth Substance Use Disorder Treatment and Recovery, implements a statewide system of care for youth under age 21 with a substance use disorder. Currently there is no such system. They are hoping to fund it through Proposition 64, the Adult Recreation Marijuana Initiative.

SB 1010, Supportive Housing, is a pilot for parolees with mental illness. It makes changes to the Integrated Service for Mentally Ill Parolees program, and authorizes a pilot for one or two counties where they can enter into a Memorandum of Understanding with the California Department of Corrections and Rehabilitation to receive funding and then administer the program.

The CBHDA is supporting AB 2333, which would add a Deputy Director to the Office of Emergency Services (OES). Not all disasters are floods, fires, or landslides – this bill is intended to help people experiencing trauma from man-made issues such as shootings. The bill was passed in the Governmental Organizations Committee in the Legislature.

There are state budget advocacy issues such as an Incompetent to Stand Trial (IST) Diversion Proposal. The Governor has proposed $100 million to be utilized over three

years to divert people from state hospitals; rather their issues will be addressed in the community – the least restrictive environment.

The CBHDA is supporting the Governor's budget that has proposed $134 million of the General Fund for the Organized Delivery System for Drug Medi-Cal expansion. This means that we will get paid for all the services we provide, allowing us to leverage our Substance Abuse Prevention and Treatment (SAPT) block grant so we can provide more care to people who have a substance use disorder.

The CBHDA is looking at changing the way we receive payment, looking at possibly working with managed care groups to provide service to people considered to have Mild to Moderate mental illness, not just the Serious and Persistent mentally illness.

All of the bills are shown under Legislation on the website cbhda.org, as well as a report card from last term showing all of the legislation with grades that reflect behavioral health issues.

Questions and Discussion

Ms. Shaw asked about the ISTs that remain in the community – how will they be housed? Ms. Kelley responded that the money is partly intended to be used in development of those housing programs.

6. Public Comment

Ms. Comstock expressed concern about AB 2333 that more due diligence is necessary in how it is written. The OES may not be the correct department to receive the Deputy Director – it may be the California Department of Public Health (CDPH). Ms. Kelley stated that the CDPH is already involved in addition to the OES, but neither has expertise in behavioral health.

7. Voices of Recovery

Ray Mills, Executive Director of Voices of Recovery, began the presentation.

- Voices of Recovery models kindness from the top down. Mr. Mills described the formation of Voices of Recovery which involved input from the whole community. They wanted to create a place where all in recovery was welcome; it had to be a broad-based advocacy peer-to-peer organization.
- Peers are models and they give hope, which is the foundation of the program.
- The success rate is 100% and no one has relapsed.
- Voices of Recovery prepares people to be in society, teaching them skills and helping them to get a recovery foundation.
- The Wellness Recovery Action Plan (WRAP) is a plan for each individual. It is one of the strongest preventers of relapse because it gives a structured guideline. There are seven WRAP groups in progress throughout the county.
- Voices of Recovery tries to reach the entire community – anyone is welcome.

- Family members who are affected by other peoples' addiction can be in WRAP groups.
- Voices of Recovery is not a treatment program or an outpatient program, but a community organization.
- When people come out of treatment programs, they are still ashamed and afraid, especially those coming out of jails and prisons. It can keep them stuck. Voices of Recovery provides a foundation for them to gradually re-enter society.

Melissa Greenfield, Certified WRAP Facilitator, continued the presentation.

- Hope House is a women's program in San Mateo County. They offer a transitional home for women to live in while working part-time; the women are charged 25% of their income.
- When Ms. Greenfield speaks at Voices of Recovery as a peer, people approach her to say they want what she has.
- She spoke of the problem that people want to work as peers, to share their lived experience, but because they have a record, they are denied the job.
- The issue that may need policy advocacy is housing for mothers with children. As they complete programs, there is nothing available in this county. Transportation is also a pressing need for individuals going through recovery: a bus pass, a bicycle, a car.

Christina Hagen, spoke to the Planning Council.

- One of the most important principles of recovery is giving back. Ms. Hagen is now a recovery coach, almost a certified WRAP facilitator, and a health coach at Total Wellness (a county program serving severely mentally ill clients).
- Ms. Hagen hopes that we can train more peer mentors. She would love to see a nationwide database of all sorts of recovery coaches – easily accessed by veterans, survivors of domestic violence, those with dual diagnosis mental disorders, LGBTQ+, those with substance abuse, seniors, and suicidal teens.

Questions and Discussion

Ms. Mitchell noted that in her county, she has partnered with a group that receives bicycles and rehabs them, then gives them to Ms. Mitchell's organization.

Ms. Rangel asked if the program extends beyond San Mateo County. Mr. Mills stated that as of today it is only in San Mateo County, but they have a vision for it to extend to other counties and states. They are a part of the Association of Recovery Community Organizations which is throughout the United States. Mr. Mitry added that Voices United (in Santa Clara County) helped Voices of Recovery get started.

Mr. Leoni noted that the concept of recovery was borrowed from the substance use community by the mental health alliance, although WRAP was borrowed from the mental health alliance. Recovery in mental health is a little different from recovery in substance use. He added that giving people hope is central in recovery for both. He shared that

lived experience is not just of the mental illness – it is also the rejection, the poverty, etc. Recovery involves all those facets.

Ms. Hart affirmed for the speakers that this is why the Planning Council members continue this work: for all those in the room whose lives have been touched by mental illness and substance use.

8. Public Comment

Carlotta Jackson-Lane, San Francisco Mental Health Board Commission, affirmed that they use WRAP and it is a very powerful tool. It can also be used in suicide cases. She commented that San Francisco has a program called Clean Slate for getting records clean so clients can find employment. She suggested for Voices of Recovery to try getting funding from private sources, as they do in San Francisco, to help generate contracts for higher salaries for the peers.

A member of the public agreed with Mr. Leoni that lived experience entails more than just mental health issues. She spoke of the value of having diversity in the judiciary on all levels. She also voiced concern about residential care facilities prioritizing provider pay rates as an important issue – more important is the issue that residential care facilities are now functioning as mini-institutions that warehouse people. We need to find innovative ways to maximize people's independence with quality resources.

Ms. Taylor thanked the speakers for their work.

9. Update from Steinberg Institute

Speaking from the Steinberg Institute were Adrienne Shilton, Government Affairs Director, and Adriana Ruelas, Legislative Director.

- The Steinberg Institute is a nonprofit that was created by Mayor Darrell Steinberg, author of Prop 63.
- Their mission is to advance sound public policy and inspire leadership on the issues of mental health. They sponsor bills and try to inspire legislators and others to take on mental health as a top priority in terms of their public policy agenda.
- The Steinberg Institute is small with a staff of five. They are based in Sacramento.
- Ms. Ruelas has a long background in the Legislature. She works on issues of homelessness, criminal justice, college-age youth, and all youth.
- The Steinberg Institute is working on AB 1971 authored by Santiago, Friedman and Chen. It addresses how to provide medical help to the homeless population. It would add the need for medical help to the "gravely disabled" definition in the Lanterman-Petris Short (LPS) Act. (The Disability Rights proponents oppose the bill.)
- The Steinberg Institute is sponsoring SB 906 Peer Certification, a bipartisan bill authored by Bell and Morelock. There is more momentum going into this

legislative session in terms of the number of states who have implemented peer certification – over 40. Individual members of the CBHPC have sent support letters. The bill has passed out of the Senate Health Committee and has gone to the Senate Appropriations Committee.

Mr. O'Neill asked if they have DHCS support. Ms. Shilton replied that DHCS offered amendments in 2016, and the Steinberg Institute is taking a look at them with its partners (including the counties and the CBHPC).

- The Steinberg Institute is also backing legislation on supporting employees with mental health challenges in the workplace – not just in the public mental health field, but more broadly in the private sector. SB 1113, authored by Monning, is cosponsored by the MHSOAC to put in place the first voluntary standard for employee mental health in the workplace. It has promise to help break down the stigma and deal with mental health more broadly.

Questions and Discussion

Mr. Leoni voiced frustration with some of the positions and language coming out of the Steinberg Institute. Regarding AB 1971: the MHSA held a battery of techniques to be able to reach people without having to use coercive pressure – the village-style outreach. Because of the Great Recession and a variety of other reasons, the promise didn't really come through. The Village technique espouses using the necessary weeks or months it takes to engage a person, but we are failing to do what Prop 63 said. The words used in the bill – "gravely disabled" – can take on a life of their own.

Mr. Leoni objected to the continued use of the phrase "brain disease." He believes that biology is a big part of this, yet he also believes that on one level, a consumer's spiritual experience can be accessing parts of the mind that have self-healing properties. Terms such as "brain disease" can actually increase stigma because they mark people off as separate. Use of these terms prevents us from working with the person in all ways possible. In addition, it hurts to be categorized as a person with a brain disease.

Mr. Leoni suggested that clients and family members need to be in on discussions; their perspectives need to be considered.

Ms. Mitchell asked about the method of getting perspective and feedback from a wide constituency of people involved with mental health policy, before these legislative proposals are put forward. There are a number of them here that the CBHPC is actually opposing at this point, such as SB 1004 on Prevention and Early Intervention (PEI). Ms. Shilton clarified the intent of the bill: to provide a more strategic framework around PEI. The concern is that we are not able to tell a statewide story and have statewide impact with the $400-$500 million investment going out to counties every year. They are going through a public policy process in the Legislature.

Ms. Ruelas added that the Steinberg Institute very much values the feedback. It is actually early in the legislative year, and these conversations are perfect for shaping the final policy. She agreed with many of Mr. Leoni's points regarding AB 1971; they feel the caution to make sure that the civil rights piece is never overlooked. Assigning names and capturing all the different views is very difficult. We want to be vigilant about law

being implemented correctly. As to the Steinberg Institute coming up with its agenda – it is this type of conversation that informs us. We are completely open.

Ms. Mitchell responded that it seems like strange methodology for a bill to be developed, and everyone else is then in the position of trying to get the language modified – rather than seeking input on the front end.

Ms. Rangel noted that at the Department of Corrections, a huge obstacle is that the MHSA specifically excludes parolees from accessing any services funded by the MHSA. It has been an ongoing issue.

Mr. O'Neill spoke in regard to the PEI bill: his biggest concern is that it gives more oversight to the MHSOAC. Sometimes they make regulations that rural counties simply cannot follow. It would utilize all their revenue if they did the evaluation or followed the regulation the way the MHSOAC wants. Ms. Shilton responded that the Steinberg Institute is continuing to work with the MHSOAC on that language. In the budget process, an idea of an "Innovation Incubator" is being floated by Toby Ewing to give technical assistance to counties on developing their innovation plans on the front end.

Chairperson Mitry commented that the bill currently prioritizes programs at colleges for Transition-Age Youth (TAY) over programs for TAY who are not in colleges. Youth of color are disproportionately not in college. This is an important area that cannot be ignored. Also, when it comes to psychosis and mood disorder detection, we should not discount the Older Adult population. We need to target that particular group because of the lack of support compared to other groups. Men are often reluctant to seek help, and are often perceived as being independent and stable, but we are not thinking about their risk. These matters need to be looked at in more depth. Ms. Shilton responded that one of the amendments they are going to take clarifies that the Early Psychosis and Mood Disorder Detection category is for services across the lifespan. Chairperson Mitry noted that trauma can re-emerge in the later years.

Ms. Nepomuceno asked if SB 1004 strips the funding from adults and gives it all to children. Ms. Shilton stated that the Early Psychosis and Mood Disorder Detection category is not exclusively for youth. She said that they are putting these priorities in the bill, but specifically asking the MHSOAC to finish this framework. For example, they are going to add some intent language about the need for older adult services; this is an important PEI population.

Ms. Moore thanked the speakers for presenting AB 1971. She noted that there are many difficulties any time you look at ending a person's agency and substituting another. In hearings, during debates on whether a person needs to stay in the hospital or not, the illness may not be recognized or understood.

Regarding SB 1004, Mr. Leoni recognized the idea of being strategic and identifying an illness in the early years. Still, the funding should not be given all to the youth. Ms. Shilton noted the significant tone currently in the Legislature about the MHSA: a number of bills concern the unspent funds. There is even a bill to move all of the dollars that were reverted from the counties to the cities and the special districts, which do not deliver mental health services.

Public Comment

Ms. Taylor commented that the method by which SB 1004 was written was decidedly paternalistic. People with lived experience know their needs better than Mayor Steinberg. The process should be reversed: the Steinberg Institute and those legislators should have gone to the community and asked how PEI dollars are currently being spent, and how outcome measurements can be obtained.

Ms. Jackson-Lane, Executive Director of Sojourner Truth Foster Family Service Agency, Inc., stated that there needs to be a way for both older and younger populations to be addressed for what they really need. Youth have been misdiagnosed or not diagnosed at all; that is why there is an urgency for funding around early psychosis and schizophrenia, with a direct crossover into high rates of suicide. To maximize what the dollars are used for, we need to address the details of servicing the consumers. Further, a Strategic Plan will result in getting the data that is needed.

Richard Krzyzanowski, serving on the CBHPC Patients' Rights Committee and many other organizations, commented on AB 1971. It is taking a dangerous gamble. The expansion of the concept of "grave disability" will translate into an expansion of involuntary treatments and an erosion of people's civil rights. When this bill goes before the public, people will vote for what they think is a solution to homelessness. However, real solutions deal with housing, jobs, and a livable working wage.

A member of the public spoke regarding SB 1004: it is very important to pay attention to the individual needs of the various jurisdictions. Also, regarding the issues of suicide prevention and homelessness, there seems to be inattention to the aging population – which has the largest increase and the most vulnerability. Regarding SB 1113, she hoped there would be attention to confidentiality and care given to not stigmatizing. Regarding AB 1971, broadening the criteria for institutionalization is not the answer. We need better access to services.

10. Evaluation of the Meeting

Ms. Wilson thanked Mr. White for the Each Mind Matters packets.

Mr. White thanked Chairperson Mitry for being a great Chair.

11. Adjourn

Chairperson Mitry adjourned the meeting at 12:05 p.m.

__**N**___ **TAB SECTION** **DATE OF MEETING** 6/21/18

MATERIAL PREPARED BY: Adcock **DATE MATERIAL PREPARED** 5/30/18

AGENDA ITEM:	Approval of WET 5-Year Plan Budget 2018-19
ENCLOSURES:	

How this agenda item relates to the Council's Mission.
The CBHPC evaluates the behavioral health system for accessible and effective care. It advocates for an accountable system of responsive services that are strength-based, recovery-oriented, culturally and linguistically competent, and cost-effective. To achieve these ends, the Council educates the public, the behavioral health constituency, and legislators.
This agenda item facilitates the Council's statutory requirements contained in Welfare and Institutions Code Section 5820(e) to review and approve each Five-Year Plan. In order to have a BH system that is accessible and responsive, a diverse and qualified workforce is needed. California is currently experiencing a workforce shortage crisis.

Background/Description:

In January 2014, the Planning Council approved the current Workforce Education and Training (WET) Five-Year Plan. The current Five-Year Plan will expire June 30, 2019, however, current WET funding for the Plan ends on June 30, 2018. Recent legislative activity to fund the final year of the Plan indicate possible positive outcome. As a proactive measure, the Office of Statewide Health Planning and Development (OSHPD) is seeking the Council's approval to ensure rapid implementation should the funding be approved by the Legislature and Governor.

The current 5-Year Plan can be found at this link:
http://www.oshpd.ca.gov/HWDD/pdfs/WET/WET-Five-Year-Plan-2014-2019-FINAL.pdf

Motion: To approve the Fiscal Year 2018-19 budget for the Workforce Education and Training Five-Year Plan.

__**O**___ **TAB SECTION** **DATE OF MEETING** 6/21/18

MATERIAL PREPARED BY: Boese **DATE MATERIAL PREPARED** 5/30/18

AGENDA ITEM:	Overview of Patients' Rights Advocacy in Orange County Jails
ENCLOSURES:	

How this agenda item relates to the Council's Mission.
The CBHPC evaluates the behavioral health system for accessible and effective care. It advocates for an accountable system of responsive services that are strength-based, recovery-oriented, culturally and linguistically competent, and cost-effective. To achieve these ends, the Council educates the public, the behavioral health constituency, and legislators.
This agenda item will inform the Council and public about patients' rights advocacy, an important (and mandated) aspect of local behavioral health systems. Specifically, this presentation will also provide knowledge and perspective on the treatment of inmates with mental health needs, which is a salient topic in the behavioral health field.

Background/Description:

Patients' Rights Advocates provide support and a voice for inmates receiving mental health services in the County jail by investigating and responding to inmates' mental health complaints and concerns. Advocates also educate Jail Mental Health staff on patients' rights issues and provide representation at certification review hearings. Advocates from the Orange County Patients' Rights Advocacy Services team will presenting on their work in the Orange County Jail. Discussed topics may include: Patients' rights issues in jails, how PRA's navigate the systems involved, relationships between PRAs and the OC Sheriff's Department, and other aspects of this vital work.

Presenters:
Gerry Aguirre – Service Chief I
Katy Orlando, RN – Patients' Rights Advocate
Patti Yamamoto, RN – Patients' Rights Advocate
Jim Marquez, IMFT – Patients' Rights Advocate

__**P**___ **TAB SECTION** **DATE OF MEETING** 6/22/18

MATERIAL PREPARED BY: Adcock **DATE MATERIAL PREPARED** 5/29/18

AGENDA ITEM:	Cultural Humility/Awareness
ENCLOSURES:	

How this agenda item relates to the Council's Mission.

The CBHPC evaluates the behavioral health system for accessible and effective care. It advocates for an accountable system of responsive services that are strength-based, recovery-oriented, culturally and linguistically competent, and cost-effective. To achieve these ends, the Council educates the public, the behavioral health constituency, and legislators.

This agenda item specifically relates to the cultural and linguistic competency, awareness, responsiveness and humility needed by advocates and also providers, persons with lived experience, and others, when interacting with individuals of another community. Other communities can include age/generational, regional/geographic, gender identity/sexual orientation, ethnic/racial, occupational e.g. veteran or first responder, and religious/spiritual to name a few. In order to fulfill our mission as advocates and leaders, we must be fully informed and practice Cultural Humility, Implicit Bias and appropriate Cultural Responsiveness.

Background/Description:

The Council has a long history of active advocacy for the reduction of disparities for un- and under-served populations in California. California's rich diversity demands that programs and service delivery be designed to accommodate other cultural perspectives, practices and beliefs as our residents come from virtually every country in the world. Culture does not only mean racial or ethnic groups, it can also include other types of communities such as Veterans, LGBTQ, Older Adults, and religious/spiritual, etc.

As advocates and representatives of our own individual communities, Council members bring their unique understanding, acceptance and bias to the verbal language we use as well as body language and behaviors, whether conscious or not. This agenda item will continue the learning and understanding of our own cultural awareness and openness to the important practice of cultural humility and responsiveness.