

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEETING MINUTES
April 16 and 17, 2009**

**Crowne Plaza Hotel
Los Angeles International Airport
5985 West Century Boulevard
Los Angeles, CA 90045**

CMHPC Members Present:

Dale Mueller, Chair	Joe Mortz
Celeste Hunter, Past Chair	Lana Fraser (not present Friday)
Sophie Cabrera	Daphne Shaw
Jim Alves (not present Friday)	Karen Hart
Caroline Casteneda	Gail Nickerson
Shama Chaiken	Lin Benjamin
Dennis Beaty	George Fry, Jr.
Jonathan Nibbio	Jennie Montoya
Renee Becker	Jim Bellotti
Barbara Mitchell	Stephanie Thal
Adrienne Cedro-Hament	Susan Mandel (not present Friday)
John Ryan	Walter Shwe
Carmen Lee	Sean Tracy (not present Friday)
Edward Walker	Beverly Abbott
Luis Garcia (not present Friday)	Shebuah Burke

Staff Present:

Ann Arneill-Py, Executive Officer
Linda Brophy
Michael Gardner
Karen Hudson
Brian Keefer
Andi Murphy
Narkesia Swangian (not present Friday)
Tracy Thompson
Lisa Williams (not present Friday)

Thursday, April 16, 2009

1. Welcome and Introductions

Chairperson Mueller called the meeting to order at 1:07 p.m. Planning Council Members and guests in the audience introduced themselves.

2. Measuring Access to Mental Health Services (MHS)

Sophie Cabrera, DMH, provided a slideshow presentation. She noted three components of measuring access to MHS:

Prevalence rates represent the number of people in California with serious mental illness (SMI) and serious emotional disturbances (SED) across various demographic characteristics, such as age, gender, and race/ethnicity. The rates tell how many people are being served, compared to how many people are in need of services. They are calculated by dividing the number of individuals who have SMI or SED by the number of people who actually receive public mental health services.

Retention rates provide information about disparities in service quality across age, gender, race and ethnicity.

The combined information shows the **Penetration rate**, an indication of the effectiveness of public mental health services across different demographic characteristics.

Ms. Cabrera presented a variety of graphic formats that provided comparisons of:

- clients served;
- the number of service days and types of services received, by race/ethnicity;
- total clients served and days of service, by age and gender; and
- the Prevalence, Retention, and Penetration rates by gender and age.

She noted that “Holtzer data” is used when compiling the rates because it was available by county. She also stated that the relative accuracy of Penetration rates can be impacted by inconsistencies in reporting, in definitions of SMI and SED, and by out-of-date census population estimates. DMH and the Planning Council are in the process of developing workbooks of similar data for each county.

Questions/Answers/Comments with Ms. Cabrera

Adrienne Cedro-Hament: I did not see anything on linguistics and am wondering if they are included.

Answer: It is included, although for presentation purposes we only used age, gender, and race/ethnicity. There is more comprehensive data in some of the detail on the Holtzer reports.

Adrienne Cedro-Hament: The *other* category in Los Angeles has always been high. We question sometimes what *other* means. At the state level, have you thought of making some different categorizations of *other*?

Answer: It varies depending on the information reported. In our data, in those instances where you normally have “male” or “female” for *gender*, if it has *other* or *unavailable*, it usually means that it simply wasn’t reported. Our system captures those things that are affirmatively reported, so if it’s left blank, it’s going to fall into *other* or *unavailable*.

John Ryan: The *gender* chart assumes that the male/female population in California is roughly divided evenly. Is there some assumption about what percentage of females would meet the target definitions? Is that percentage greater for males, or is it the same roughly 10%?

Answer: We use Holtzer’s definitions of what the target population would be. I’m not familiar with how he derived the percentage of males versus females to be included in his target population. I don’t know what methodology he used.

John Ryan: It almost seems as if this is saying that there are more women who meet the definition of SMI than men.

Answer: That would be the assumption: unless the total population for males and females is that same percentage, then the total number of females who fit the target definition would be higher than males.

Gail Nickerson: One factor that you’re not considering is poverty level. Part of what Holtzer is looking at is people who are under 200% of poverty level. So what this is telling you is that there are more poor women than poor men, besides what their SMI status is.

(*Beverly Abbott* clarified that Charles Holtzer is a researcher who previously worked at the University of Texas. He used several nationally based studies that looked at the prevalence of SMI and Serious & Persistent Mental Illness (SPMI), and applied them to a variety of demographic characteristics – age, race/ethnicity, gender. The prevalence rates that are used for our purposes here are those for SPMI, so they are higher, around 7% and 8%. They represent the rates applied to persons under 200% of the federal poverty level, because that poverty level is determined to be the one that most corresponds with clients who would be eligible for services in the public mental health system.)

John Ryan: If you take a look at all these unmet needs: the difference between the number of people that the system could serve versus how many are actually being served; how is that prioritized out? What’s the highest unmet need versus the lowest?

Answer: I don’t know if there’s a simple answer for that because I think you would have to do comparisons across not just gender, but a combination of gender, age, and race/ethnicity; and maybe identify those areas where you see the most prevalence across all demographics, and use those. Again, the data will give you an overview of what’s happening in your county and what’s happening statewide. How you compile that data and the types of assumptions you make about where to place your efforts and your money is going to depend on what you’re seeing in your county.

John Ryan: I have an assumption or belief that older adults represent, if not the largest, then the next to largest group of people in the state whose mental health needs are underserved.

Answer: When you look at the disparity between the target population and the served population, there's the 25-44 age group. Then you move to the 45-54 group, a little less. 55-64 looks about even, and then 65 and over. So the biggest disparity actually appears to be between the 25-44 age population. This is a statewide view, so in your particular location you may see differences.

Lin Benjamin: Related to the older adult question, one of the limitations of the Holtzer data is that it doesn't break down 65 and older by 5- and 10-year increments. You may see underserved influences if you break it down. Data that I've looked at shows that those within 65 to 75 may be better served or have more utilization of the system than those who are over 75. You may see greater underutilization in the older age groups within the public sector.

I believe that the Holtzer data has limitations. You can't break down the 65 and older group. There is a 40-year age span; we serve older adults in the public sector system, ages 65-105. We can't get a sense of the utilization with some specificity. That's data that would be useful to have when you're looking at the variation in the older adult population, and who's being served by the system.

Beverly Abbott: The Women's Mental Health Policy did a study on the age range issue that showed a disparity between women and men, but also showed that women are not served in their younger years. When they get older, they tend to show up more in mental health programs. That's one thing I'd like the Planning Council to look at. In terms of *unavailable* data, it looked like there were more *unavailable* data for the 5- to 10-day increment than the beginning increment.

Answer: This is by number of days of service, so people have afforded the number of days of service, and there was more *unavailable* for that particular type.

Shama Chaiken: Regarding Prevalence rate based on ethnicity: The current census shows California is 36% Latino. The Prevalence rate for Hispanic is through the roof. Based on the census, it would seem that four times as many Hispanic people are diagnosed with SMI. I've seen some research, and it could be that there are more people who are eligible because of the poverty rates, but I don't think it's possible that that in itself explains the quadrupled rate. I've seen studies that show that clinicians are more likely to diagnose people whose culture they don't understand, or people with darker skin colors. I wonder if we have a diagnostic bias or some other problem with the data in looking at that population.

Barbara Mitchell: That is explained by the poverty index. In Monterey County, when you look at who is on MediCal and what the poverty index is, the huge majority is Latino. There is already a majority of Latino residents in the county. I think it is based on poverty index and not cultural diagnosis.

We've struggled with the state definitions of Hispanic and Latino. California uses the definition *Hispanic* as a racial/ethnic group, where the federal definition is *Latino*. Most Latinos pick *other* or *Native American* as their racial/ethnic group because they are confused. Could you discuss the disparity between the state and federal definitions?

The federal government does not consider the term *Hispanic* a racial/ethnic group anymore. Is California data taking this into consideration in terms of who is served and how it's reported? Many of us have multiple funding sources. When you're collecting data, it depends on how you do it. If you're collecting data from a program that also has federal funding, you wouldn't be including "Hispanic" as one of the racial/ethnic groups.

Answer: I don't know the impact when you go across to federally funded programs.

Rachel Guerrero, DMH: In our CSI data system, we had a committee that the department put together to look at city data. We broke out Latino data. When the county reported who they were serving, Latino is broken out as a community, as are the other racial/ethnic groups. Latino has never been defined as a "race." The federal government uses African American, Native American, Asian/Pacific Islander, and White. Only counties can pull out Latino data, as opposed to the federal government.

Luis Garcia: What is the priority for reviewing the gaps? How will we review our existing gaps?

Answer: We need to establish some priorities for the demographics we're going to target first. We want to present state-wide data as well as county data.

Celeste Hunter: The ethnicity/race slide shows that more African-Americans received service than the number targeted. How did that happen?

Answer: That encourages us to take a look at why this is happening. We see only data; it gives us a starting point to ask questions.

Lin Benjamin: Can this data be generated to show a combined analysis of racial/ethnic/age/gender? You would be able to figure out who is underserved, which would influence your outreach and service development strategies.

Answer: There isn't a way to combine the data and get an overall look; there's no cross-calculation.

John Ryan: Does this data factor out the poverty issue, or is it strictly racial/ethnic, age, and gender?

Answer: Poverty was part of the calculation in who was established as a target.

Ed Walker: The age distribution slide shows that the served group is defined as those who are provided services in California Public Mental Health. Somewhere between the ages of 18-21, foster care youth lose their MediCal eligibility. They "age out." Since California long ago became principally a MediCal system for out-patient services, its emergency and in-patient services for the age group of 25-44 are primarily uninsured. This is a problem the CMHPC has raised for many years -- the effect of being uninsured, coupled with the poverty factor, resulting in a large group of people needing services who are not being served.

Joe Mortz: In response to Dr. Garcia's remarks: How would it be if the DMH and the Agency were to take these disparity rates, by the state levels and the county levels, and send annual reduction targets that eliminated these disparity rates within ten years? How about using this information to start eliminating the disparity of service, rather than us just looking at the disparity every few years? Let's start looking at the *reduction* of the rate of disparity, and targeting the reduction of disparity at the department and agency level. These rates are not just mental health; they're also health and social service rates.

Chair Mueller: Regarding the shifting demographics and the changing proportion of age groups in our state, trends we see now may shift in ten years as the age groups get older. The groups are not static.

Answer: The department has a newly-developed evaluation unit that will be looking at all the data coming in from all the reporting sources in the state. It will be making some findings for the department, so that we can actually start doing some trend analysis and seeing if we need to put effort into other areas.

3. Report from the Department of Mental Health (DMH)

Sean Tracy, Chief, DMH Office of Strategic Planning and Policy, gave the report. Highlights included:

- He complimented the Council on its expertise and talent, and on its knowledgeable and forward-thinking questions. DMH carefully considers Council questions as they work in tandem with other key partners -- consumers and families, the OAC, and the Mental Health Directors Association.
- He relayed DMH Director Stephen Mayberg's message to the Council: to continue to work together; and to remain thoughtful about the entire system and the long-term situation, in the midst of this economic downturn and all its pressures. DMH is working as fast as it can on areas it thinks are of benefit to the system -- processing contracts, paying claims, being clear about regulations, and organizing better to provide better services. With so many changes and the resultant pressures, there is conflict sometimes, but keep the dialogue going between DMH and the Council. Don't let the *perfect* be the enemy of the *good*. Don't let process kill the ultimate result of what we want to do across the system.
- Stan Bajorin is now Acting Chief Deputy, as well as Director of Administrative Services. Denise Arend is the new Legislative Deputy. Tina Wooten has rejoined DMH as its Consumer and Family Client member in the Director's Office.
- DMH invites, expects, and needs CMHPC's counsel. The process that Executive Officer Ann Arneill-Py uses to get ideas to the DMH through letters and comments is very helpful, and DMH would like to continue that. It also would like to have her and other members in direct conversation at the executive table. Dr. Arneill-Py is a fantastic advocate and helps us out there.

- There is a significant effort to reform the claims payment system. They are targeting implementation of the reform in February 2010. The goal is to turn around payments and claims to the counties in 30 days. Testing of the reformed system will begin in September 2009 with the counties.
- Everyone is anxious to know the implications of the results of the May 19 Measure 1 A-F election. DMH hasn't made decisions on what's going to move and what's going to stay; it will wait for the election results and then decide.
- DMH has been working since September 2008 on a Strategic Plan. It has established values, vision, mission and goals in the department, and will be rolling that out across the organization so their employees can take a look at it and then to others external to the organization in May and June. Mr. Tracy stated they hope to present the Strategic Plan, along with the Business Plan, at the June meeting.
- Therapeutic Behavioral Services (TBS): DMH has been under litigation for 10 years for a case involving delivery of TBS. The settlement team, which involved providers, counties, plaintiffs, and defendants, under the direction of a special master, has developed a 9-point plan that has been issued into an Information Notice for the counties to implement. DMH hopes that the court will give it an exit strategy in April.

The "T" in TBS can stand for Trust and Transparency. When we try to make improvements to the system, it requires a great deal of trust that the agreements are going to stand, that we're clear about where we're going; and that we can see it. People outside our organization must be able to see it also, and test us about it. In the TBS process we've made commitments that everything is going to be public. A lot more information will be available to everyone.

The "B" in TBS can stand for Budget and Business. How will we manage going forward? That is Issue #1 for many of us.

The "S" in TBS is Services and Strategy. The change in our Community Services Division represents a different way of doing business, and we think that, ultimately, this transition will serve you better. For those of you who contract with us, we have a Contracts Office that you can get answers from, instead of trying to find them across the organization.

- Everyone agrees that Electronic Health Records (EHR) are a good direction to go in, but it's a huge undertaking. Just trying to get our claims changed has been a long and arduous process, but going to EHR is important.

Questions/Answers with Mr. Tracy

George Fry: What is the status of the court case for AB 2034?

Answer: It's still in court, and the litigation continues.

Joe Mortz: I've been in a number of counties where the department head each month puts out a written statement on the status of the department. Those counties seem to have really effective public input programs. I'd like to know if that idea has been considered at the DMH? San Diego County has one that works well. They state the major initiatives in the department, any changes that have occurred, initial budget summary, highlights of particular programs; similar to each of the items you did today. Then, when the director gives his report at the Mental Health Board, he's able to make a personal commentary, and build a relationship, whereas the data is available independently.

Answer: The Progress Report for MHSA was done for awhile, but I think we haven't done that for several months. I'll take that back to External Affairs and Communications and see what we can do to talk about a monthly newsletter. It's a good idea.

Susan Mandel: We're all experiencing tremendous change. But it's incumbent upon us all to remember that in the work that we do, it's all about relationships, whether it's at the service level or at the governing level. Several times during your report you referred to the four groups (OAC, etc.), and I think we've all been receiving information from community partners (client groups, etc.). We need to remember that, as we plan for the future, everybody needs to be engaged and involved. The way may be different, but we have to include our community partners. My own experience is that one of the things that suffered during this restructuring is communication. It has been less than usual. If anything, communication needs to be more than usual during times like this, so that people don't feel left out, and don't misunderstand the process.

Answer: I talk about being reminded of the right partnerships to use and the right language to include; you're absolutely right about that. In the work we're doing in the Department, many of you may be involved with the mental health MediCal workgroups DMH has been running for about a year now. They have grown from being a conversation between the county and the state, to providers, to consumer family members, to the Planning Council. That has enriched the conversation and been very helpful.

Adrienne Cedro-Hament: A few years ago the Planning Council started to talk about a DMH cultural competency plan. You know that counties are being asked to have their own cultural competency plan. The Planning Council has asked the State Department for its own cultural competency plan. Developments were that it was given to Rachel Guerrero to take the lead, Mike Burunda said that they were starting to do some in-service training among the staff, and that later on, with the influx of MHSA tasks, there were changes in staffing. There have been a number of reasons why the DMH has not come up with its own cultural competency plan.

The Council understands those things but is there a thought of making some transformations in the system? Yesterday Sophie Cabrera gave Council members a copy of an organizational chart of one portion of the entire DMH. When I looked at it, there were something like 17 vacancies. When the DMH does recruitment, do you use ethnic, age, or gender considerations? Or do you just interview whoever might qualify? Is there

a desire to have some ethnic balance? **Answer:** We've had very rich ongoing conversations about cultural competency across the state and also inside DMH. As you know, when you go out recruiting, and look at your workforce development, and consider the skills and talents of people that come to work for you, that is absolutely at the forefront of discussion. We know that California is changing demographically and socioeconomically, and we are always paying attention to that. Among the deputies, chiefs, and managers at DMH, that is very much a priority

Adrienne Cedro-Hament: I was wondering if Marti Johnson and Sophie Cabrera could come up with something like the demographics of just your organization. Who are the people there in terms of gender, ethnicity, age? Then, what do you do with this data? Is there a desire to make some changes, or is it just to take a look at the data and that's it?

Answer: One good point you make is to take a look at the Community Services division. The majority of our employees come from our hospitals; about 10,000 of our employees are in our hospitals state-wide. We do collect data; we'll take a look at it. Maybe we'll bring it back in June and see what we've got.

John Ryan: The Council has taken the position in the past that DMH should develop a cultural competence plan. Adrienne highlighted some of the history of what happened in the past. As I remember, Dr. Mayberg made a commitment that when DMH does a strategic plan, a component of that will be a cultural competence plan. Is that part of the strategic plan?

Answer: (from Rachel Guerrero) Absolutely. Every division chief or deputy is required to write their component of the department strategic plan. The overall missions, values, etc. have been done, but I have the task of writing the cultural competence component. Dr. Mayberg and I have talked about that, and he has asked me to put it in my deliverable to the strategic plan. This would include some of the data you were talking about before. We have some drafts thus far.

John Ryan: Regarding the Proposition, I understand that no decision has been made about what will happen if this thing passes. Has DMH talked about a process that it will engage in for deciding where that \$200 million is going to come from for the next three years?

Answer: Yes. We will have to go to Agency, the Department of Finance, the Governor's office, and get some guidance and direction. I don't know what the process will be, but I can certainly find out.

Jonathan Nibbio: One quick comment and a question from the Children and Youth Committee perspective: related to TBS, it's a topic we've been tracking here since its inception. I attended a meeting for development of the training manual for TBS, and I must compliment the spirit of the whole group and its cross-representation. There really is a commitment to making the services about those kids that need it, and transferring those skills to their parents. You don't often feel that when you go to committee meetings.

One of the things we've talked about is that there are kids we are not reaching and who are not getting the services. We've had a lot of focus in the last few years on the

criminalizing of mentally ill kids and around mental health courts. One of the things we talked about yesterday was asking if we could collect data on how many kids who receive TBS state-wide are actually probation youth and child welfare youth. We want to see if those numbers are increasing. We need a special emphasis on those kids between 18-21, because I think a very small percentage of those kids have received services.

Answer: One of the key components of the nine-point plan is to create data dashboards for each of the counties. We've been taking state-level data and looking at utilization/access of TBS services in each county, providing that to each county, and saying, "this is what we get from the state. Does it look right to you?" We're going to be posting that data on our website. That was an agreement we made among the settlement team members.

The second track starts to address what you've talked about, which is trying to match data across the Department of Social Services (DSS) and DMH. We have been able to negotiate with DSS and DMH data management teams to pull those records together, and we've got them. This is an unprecedented match we're doing across the system. We're hoping that during the month of May we can take a look at this, including the 18-21 year olds. We haven't quite done the work on it yet.

Track 3 is going to be pre- and post-TBS episode hospitalization. Those are the three major data tracks that we'll be doing for this process, and seeing some evidence that we're doing a better job. Jonathan mentioned an important component of this whole process: coordination of care across the systems. Part of what we're trying to have happen in local conversations is that the Mental Health Director, the Child Welfare Director, the Education Director, and the court and probation people sit down and discuss the kids who are or aren't getting TBS, and why or why not.

4. Overview of Mental Health Services Act Funding

Sophie Cabrera, Chief, Local Program Support Branch, DMH, presented a PowerPoint overview of funding collection to expenditures. She covered the following topics.

- The MHSA was enacted with voter approval of Proposition 63, which added an additional tax for each taxable year beginning in 2005; the new tax, now known as the Millionaire's Tax, is a 1% tax on that portion of a taxpayer's income that's over \$1,000,000. To understand why it's uneven: millionaires represent 20,000-30,000 returns, which is 1/10 of 1% of the total returns in the state of California; so it's actually a small number of people supporting all of the MHSA funds. In stressed economic times that tax becomes very susceptible to fluctuations.
- There are three primary sources of deposits:
 1. Cash transfers are 1.76% of all monthly personal income tax payments of everyone in the state, not just millionaires. Every month, employers

withhold income tax, and 1.76% of that is transferred into the MHSA fund.

2. Annual adjustments are the settlement between the cash transfers and the actual tax returns of millionaires. At the close of the tax year, the difference between the 1.76% amount that's been collected over the year and the amount that represents 1% of the Millionaire's Tax becomes the annual adjustment. That takes place about 18 months after the close of the tax year.
 3. Interest income is posted quarterly on the deposits that are in the fund.
- Deposits are made every month. The 1.76% tax cash transfers are deposited through January for the tax year. Interest is posted quarterly and the annual adjustment is made in July.
 - The fund balance is "lumpy;" i.e., monthly cash transfers can vary, depending on the amount of income tax collected.
 - DMH uses a *cash* basis as opposed to an *accrual* basis. Thus, when it does a planning estimate, a county can come and ask for every dollar of the estimate and DMH can provide it. Because DMH makes planning estimates based on money collected the previous tax year (on a *cash* basis), it knows how much money is going to be in that fund.

Counties receive 75% of the cash requested when their plans are approved, with the exception of the Community Planning funds. The remaining 25% is released when DMH receives required fiscal reports.

DMH wants the Planning Council to know that there's always going to be money in the account. However, it's an unsteady funding source at times because there is a very small percentage of people who support the fund. To the extent that the economy declines, the MHSA will decline as well.

5. California Mental Health Directors Association (CMHDA) Perspective on Implementation of Mental Health Services Act

The other half of the presentation was given by Don Kingdon, Ph.D., Deputy Director, CMHDA, and Small Counties Liaison. He presented pie charts that showed how community mental health funding historically has worked, and how the various parts are related to each other:

- In 1999-2000, when John Ryan was the Mental Health Director, realignment was the largest source of funding. Its primary obligation was assuring access to involuntary treatment. There was sufficient realignment funding at this time, and a fairly simple cash transfer process kept the system going while the state waited for Federal Financial Participation (FFP).

- FFP is basically federal MediCal. Claims are paid after costs have been incurred -- timeframes are anywhere from 30 days to two years.
- The Early Periodic Screening Detection Treatment (EPSDT) program was next, a part of the State General Fund.
- Managed Care was essentially a compilation of inpatient-outpatient claims.
- Overall, the system was relatively in balance, meaning that realignment could act as the cash reserves, carrying counties and their contracted providers through the 30 day to two year waiting period between when a federal claim was submitted and when you actually got paid . System funding totaled about \$2.2 billion.
- In 2004-5 things started to change. Mental health, being a non-entitlement program, got the tax revenues last, after caseload growth and other entitlement obligations were met at the county level. For mental health, realignment tended to be relatively flat.

FFP, however, was growing and represented tremendous opportunity at one level. But every FFP dollar requires a local match dollar; so FFP can actually drive all the other categories.

The EPSDT General Fund was also growing, but it requires annual state legislative approval. Managed Care was not growing much; it had suffered from lack of COLA. Also, it is General Fund and requires legislative approval.

- MHSA 2009-10. The community mental health system has become very dependent on FFP, which now represents one-third to one-quarter of the total funding. It is still a significantly delayed source of reimbursement with significant cash flow issues. In addition, since every time you bill a federal dollar, you must have a local dollar match; you are grabbing some other piece of the pie -- from Managed Care, or Realignment or somewhere else.
- If Proposition 1E passes, there will be a significant change in both the EPSDT State General Fund and in the Managed Care Funds. About \$400 million over two years will have to be transferred to MHSA to offset a portion of EPSDT State General Fund.
- By 2011-12, capital gains taxes will come to bear on MHSA. The loss of capital gains will make MHSA less a source of funding than Realignment. At that point FFP actually becomes the largest single source of funding for county and community mental health.

Dr. Kingdon paused to ask if there were any questions or comments about the pie charts.

Ed Walker: One point I'd like to make: before the federal dollar is received, if you spend a dollar on services, 50 cents will come back to you as FFP. But the county has already had to bear the cost. What happens now, when there is a failure of the state to pay? Clients who will no longer be served when there are cuts need to know when the payments will be made.

John Ryan: What has been the decrease over this period of time in State General Fund dollars to mental health?

Answer: State General Fund dollars have remained relatively flat or have decreased, except for EPSDT. If there's a redistribution of MHSA funds, then we'll also see a pretty dramatic reduction in State General Fund obligation for EPSDT. I think it will be about half of what it was for the Medicaid program.

John Ryan: The cost of business is going up, so the bottom line is that there are fewer dollars to service people other than MHSA people.

Answer: Essentially, more and more of California's mental health system is funded by three funding streams: income tax, sales tax/vehicle licensing fee, and a lot of federal money. It's less and less State General Fund.

Ed Walker: There were three years when the State of California did not give any standard cost of living increase based on the Health Market Index. The purchasing power has gone down because of that. It's taken more out of Realignment. This has further restricted what county or local mental health can provide.

Answer: It's really a difficult message. Some of you would look at \$4.6 billion and say that's a pretty healthy mental health system. At one level it is. But it's a constantly changing interplay between the various sources of funding. It's a volatile system. And it's becoming increasingly dependent on FFP, which puts a lot of pressure on local funds to act as first dollar spent.

Looking at the funding pie, there's no way to think of any one program as independent. MHSA must be thought of as integrated with Realignment, FFP, and sources of State General Fund.

Gail Nickerson: From the presentation graphics, we see that MHSA dollars are getting smaller. In actuality they're growing. Why are these dollars being spent in other places, when the original purpose was to spend them on mental health?

Answer: I agree. It was not the voters' intent to spend the MHSA funds elsewhere.

Mr. Kingdon then presented an analysis of funding and system access.

- The two-tiered system has more and more become code to a system that has a lot of differential access problems. The two-tiered system had started the dialogue, but it isn't where we are today. We are concerned about our mental health system having a lot of differential access and differential utilization

problems. From gender, age, and race/ethnicity; we have many problems we need to solve, and we won't solve them if our funds remain very categorical.

- Keep in mind: we have to address differential access. Not just from a political perspective, but also because the people who don't get care end up costing the system more in the end. Poverty tends to lead toward the correctional system, another significant problem in our state.
- We need to move MHSA funds into communities. There is no doubt that those funds are needed for California's county-operated mental health system. Once they get there, we need some important accountability structures.
- One of the important visions of the MHSA act is that we do what the voters intended. This includes preventing, not just mitigating, the negative outcomes associated with having SMI. We have a long way to go, but we won't get there if we keep these funding streams and programs categorical and don't blend them.
- We need to improve on measuring whether we provide the right amount of services at the right time. Full service partnerships may be "Cadillacs" that don't always meet the needs of consumers during their recovery.
- We cannot continue to treat MHSA as a categorical funding stream. We will need to look at MHSA as we intended it to be: a little more like Realignment, with clear, defined accountability associated with it. We need to shift our focus to measuring performance, as opposed to determining whether we got the plan right.
- The two-tiered system, again, is code for a system that has serious flaws in access. In a discussion on EPSDT children, for example, we found a bias in the system for treating boys who have externalizing disorders. We then miss the depressed girls, children in the early stages of schizophrenia and bipolar illness, etc. We have access issues and biases that need to be addressed; and MHSA is very much a part of addressing them.
- The MHSA is not a stand-alone statute; it's meant to modify current statute. It's important to this Planning Council that a part of the MHSA requires that OAC members sit as ex-officio members of the Planning Council to review outcomes. Whenever you're in doubt about what to do, you can go back and read MHSA, since it was crafted to modify existing statute and to strengthen it in many areas.
- At present, we need barrier removal. We have discussions about this at the county level and should also have them at the state level.

- In the immediate present we are proposing and working with DMH on changing and broadening some of the definitions, and looking at the current understanding for Full Service Partnerships. Stephanie Welch of our staff is working directly with DMH on this. We have FAQs in to DMH that we hope will begin to smooth this process.
- We don't want to over-categorize this program in such a way that we miss or avoid opportunities for system integration, because we're afraid of the S-word (Supplantation). It's very important that our system remain flexible. And a system can only be flexible if it's held accountable.
- Concrete strategies: first and foremost, from DMH's perspective, we need a new and different understanding for Full Service Partnerships. At the same time, we can't lose some of the core whatever-it-takes principles (especially housing).

Questions/Answers and Discussion with Dr. Kingdon

Susan Mandel: What about the current President of the State Senate, who designed this bill to replicate AB 2034, which was not a particularly flexible program? I agree with your principles, and I agree with what you're talking about, but I'm not quite sure how we get there, given the way the author wrote the MHSA.

Answer: We have the utmost respect for Senator Steinberg. His staff is interested in making sure that this money benefits communities. Also, they expect accountability. I think we align there.

Beverly Abbott: Language is important. You and Pat Ryan have said that the "two-tiered system" is code language for "complexity." But we've heard from various constituent groups that when you talk about the two-tiered system, what comes up is the "Cadillac" versus the "non-Cadillac." It might be helpful to drop that, and use "multi-tiered system." It brings up that original conflict about the haves and the have-nots. Also, I don't know if you have seen the Planning Council's letter to CMHDA about these issues. It addresses the Policy and System Development Committee's concerns and issues, and makes some recommendations. Have you seen the letter?

Answer: Yes. Stephanie did warn me not to use the term "two-tiered system," but it was already in the PowerPoint.

Joe Mortz: In my opinion, from a client's perspective, it's a multi-tiered system to say the least. *No wrong door* is a dream. There are many doors that have to be entered: the pharmacy, the doctor's, the house. We have a potential for change in the health care system in the United States. It's being seriously discussed by serious people. The Republicans in the United States Senate have said that they support a change. I'm wondering if the providers of mental health services at the county level are looking at these various tiers, since federal dollars are a big part of it, and organizing and giving any input for change at the federal level.

Answer: Absolutely yes. CMHDA has an executive director with tremendous credibility in Washington. She has been participating in the President's Health Care Reform initiative. We are reminding everyone in Washington that mental health is health and should be considered as such. The executive director was also instrumental in the passing of the Federal Parity Bill, working with Congressman Kennedy.

Joe Mortz: In this process, the elimination of some tiers could be federally stimulated. Let the states regulate aspects of their own programs.

Answer: We got rid of one tier, at least, with the Federal Parity Law.

Lin Benjamin: The term "continued care" has different meanings to different population groups. Further discussion might be beneficial as to how that's defined. Also, could you comment on MediCare as a potential payer source and what CMHDA is considering as to MediCare?

Answer: Federal parity will have an impact on MediCare. It will be slow and gradual. Over a 5-year timeframe MediCare will adjust itself to removing benefit limits that are currently in place for in-patient and out-patient copayments. As that occurs, I think that as the population ages it will become an increasing source of funding. Its biggest limitation has been serious benefits and lack of parity. One of the most underserved populations has been older adults, so there's a big challenge there.

Shebuah Burke: Regular MHSA funds were basically taken away. If everyone knows that something needs to be done, what can we, as Planning Council members, do? It looks like a train accident waiting to happen.

Answer: Yes, I believe the state has violated the maintenance of effort provisions of the MHSA. They've done it repeatedly. What needs to be done? There's been at least one lawsuit; there should probably be more. The Act becomes more vulnerable as people become more cynical. We'll see where Proposition 1E goes. The voters are not happy right now about some of these tax sources, so 1E is going to be quite a test.

6. Report from the CA Mental Health Directors Association

Mr. Kingdon also gave this presentation. He began by stating that CMHDA has two sponsored bills this year, meaning that they are able to get authors for them and are running them through the legislative process, which is one of their jobs on behalf of their members -- the County Mental Health Departments.

CMHDA has two sponsored bills:

- AB 754 - Chesbrough, is intended to amend the current statute that governs managed care in California, and the payments and claims process; and to specify, in the statutes, timeframes and processes to ensure that federal payments are made in a more timely way and, where appropriate, EPSDT State General Fund. The bill also specifies inter-agency relationships. CMHDA believes that the strength of the current program is that it's an inter-

governmental program, which allows the state and local government to work in partnership.

- AB 421 is a bill that CMHDA tried to get through last year. It cleans up some problems in the Special Education AB 3632 Entitlement Program, largely associated with placing children out-of-state.

Other hot topics from CMHDA's perspective:

- CMHDA is in the throes of negotiating the FY 09-10 MHP contract. This is the contract that comes under that statute that governs how counties implement the MediCal program in California, especially the mental health program.
- CMHDA is keeping an eye on Proposition 1E. Members have struggled with it; the greatest concern is if it doesn't pass. But if it doesn't, what will happen? There will be a \$500 million hole in the community mental health system, in terms of state funding.
- The Federal Economic Stimulus Package passed, and there will be an increase in the percentage of federal participation (FMAT), retroactive to October and going forward through December of 2010. The new percentage will be 61.59% as opposed to the current 50%.
- CMHDA is working closely with the Department of Health Care Services (DHCS) on a state plan amendment to allow for some supplemental federal payment when certain programs exceed their currently capped rates in the state system. Negotiations are probably nine months off or so with CMS, but CMHDA is very glad that DHCS has moved ahead with this.
- There is a sad lack of accountability in outcomes in the state. The Planning Council has been a champion of this problem. CMHDA wants to work with the council and challenge everyone to get some dashboards out there for counties, outcomes measured, and results posted.
- At the federal level, Healthy Families is the insurance program for children who are not MediCal-eligible, up to maybe 300% of poverty in the future. The county mental health departments are responsible for providing the SED benefit: when certain children meet criteria for SED, the counties are responsible for ensuring their access to care. With that re-authorization comes the federal parity requirements. It could mean increased access for children whose diagnoses were excluded, for example, autism.

Questions/Answers with Dr. Kingdon

Barbara Mitchell: I think elimination of adult dental is still on the table for MediCal. I wonder if CMHDA has discussed this and looked at the impact.

Answer: There are a number of things CMHDA is concerned about. Reduction of pharmacy rates is another issue. Yes, any reduction in the entitlement programs right now just frays the safety net. That is very critical.

Joe Mortz: Do you have suggestions as to how CMHPC can be performing accountability oversight, such as the maintenance of effort? I've never heard this council address the Legislature on this item.

Answer: It would be presumptuous of me to make suggestions. Asking questions such as "What's going on with the 2034 lawsuit?" publicly is important. First, don't let it fall off your radar screen. From there, I would let Ms. Arneill-Py and others answer what the appropriate role may be, particularly in terms of the maintenance effort. We definitely need some structure to work on the measurement reporting and comparison of outcomes and accountability. That's one of the core missions of this Council.

Shama Chaiken: Your efforts to get funding for out-of-state placement when an IEP requires it is commendable. Connecting that to the issue that the kids who get attention are the ones with behavioral problems -- California doesn't have great programs that are strength- and recovery-focused for kids who don't have behavioral problems but have SMI, psychotic disorders or severe mood disorders, especially depression. That seems to be the main reason kids are sent out of state -- other states have developed extraordinary programs such as care of large animals or development of artistic skills. Have you seen any effort to develop such programs in California?

Answer: The prevention/early intervention programs that the OAC is keeping an eye on do have an encouraging portion focused on early first-break schizophrenia. The council can have someone come and give an update on how many county plans are in, do they contain this component, etc. It's a critical area. How can the withdrawing be identified, not just the acting out in children and young adults?

John Ryan: Do dollars drive policy, or does policy drive dollars? I support the idea of developing outcomes. Historically, dollars have driven policy. I would like to make it different this time, and have policy drive dollars.

Answer: Well said.

7. Update on Cultural Competence Issues

Rachel Guerrero, Chief, Office of Multicultural Services (OMS), DMH, began with an update on cultural competency plan requirements for DMH, which ties in with the previous presentations, and especially the question, Has DMH set disparity targets?

A summary of her points:

- The cultural competency plan requirements for the counties are about completed. DMH has not set disparity targets because change in quality of care, appropriateness of services, and equity happens at the local level. DMH,

in consultation with community partners, has laid out a different cultural competency plan. It has a logic model of requiring counties to take responsibility to look at data across systems. The plan takes counties through a process of looking at the data from DMH and finding the disparities.

- DMH is asking the counties to set their own goals for addressing disparities, and to do their own analysis of where the barriers are in particular communities.
- The cultural competency plan is trying to move toward performance measures. Who is getting access to services? Ms. Guerrero also has a struggle with the dialogue of two-tiered system. What is needed is to get away from that dialogue and talk about what is good disparity analysis data.
- One of Ms. Guerrero's goals is to find how DMH can do a better job in looking at the data we do have. DMH should develop data standards for addressing and analyzing disparities. Standards need to be consistent so that DMH can compare across counties. Is there equity in new resources or continuing resources? One of the goals of the office, which is Ms. Guerrero's part of the strategic plan, is developing better data components.
- Penetration data pertains to only one visit per year. We've been doing this for ten years; we haven't looked at multiple visits per year. There's so much that isn't said in terms of the components. What does Holtzer's data include and not include? Ms. Guerrero has asked, in a contract with the Center for Reducing Disparities, to do a two-day conference targeted on data. It will begin to help the DMH in their performance outcomes -- how do they measure disparities? Ms. Guerrero invited the Council to the conference, entitled "Mapping Progress in Mental Health Disparities in a Transformed Mental Health System," on May 21-22.
- Ms. Guerrero acknowledged that counties feel inundated now with reports. But DMH's cultural competency plan is important because it asks counties to look at what is happening across all funding sources, not just MediCal, which is what the old cultural competency plans used to do.
- DMH is in the process of trying to complete three RFPs.
 1. The first RFP is to improve community partners input. A multicultural coalition will be created to continue to inform DMH about access at the local levels.
 2. The second RFP is going to include five contracts to five communities: African-American, Latino, Asian/Pacific Islander, Gay/Lesbian/Transgender, and Native American. A representative from each community will

submit a convincing RFP about how they would bring their communities together to help design solutions to disparities.

3. The third RFP will help pull together the strategic plans produced by each of the five groups.

Questions/Answers with Ms. Guerrero

Adrian Cedro-Hament: First, thank you to DMH for the increase in staff at this meeting: Ms. Cabrera, Mr. Tracy, Dr. Kingdon, and Ms. Guerrero. Next, can you give timelines? For example, the cultural competency update requirement will be out by May. When will the counties send it back?

Answer: The Cultural Competency Advisory Committee recommended six months for the counties to put together their plans. We will compile a list of all project timelines and send it out to the Council.

Adrian Cedro-Hament: We now have a Cultural Competency Committee within the CMHPC. How can this committee and DMH work closely?

Answer: I or another staff member can attend their meetings.

Joe Mortz: In the California system, the worker bees are the counties, and the state is an umbrella. It's definite that the counties are the ones who will set work targets, pragmatically. I have a feeling that the state is passing the buck when it asks counties to come up with target levels. The state kind of avoids the difficult issues and throws them on the people who might have the most difficulty in actually doing it. I'm concerned that the state's leadership is not as thorough as it could be. Also, in all that you've discussed, where are the state hospitals?

Answer: OMS has not had a direct role in the last six years within the state hospitals. It has targeted community mental health.

John Ryan: A process question: six months ago, OMS presented the Reducing Disparities Project and solicited feedback. How many people actually gave feedback?

Answer: OMS presented the project to OAC; MHDA; and Ethics Services managers, who sent their recommendations to the directors. OMS also did a Webinar, and had 152 people participate; they had a solicitation of letters and received around 50 from community partners; REHMCO, and the cultural brokers. They contacted the big government partners.

John Ryan: The Planning Council did not get a response back from their letter; nor did I get a response from an email I sent individually. What did OMS do with the feedback they received?

Answer: I apologize for the lack of response and I can send a formal letter back. OMS rewrote the RFP after reviewing all the feedback; the content totally shifted. Originally OMS was not going to do five separate contracts by multicultural communities, but were going to give it to one contractor. But, in summary, response from OMS to those who provided feedback was hit and miss.

8. Vital Signs: Discussion of Feedback from Constituency Groups

Executive Director Arneill-Py stated that the Council had adopted as its theme for the next year's meetings, "Looking at Vital Signs: Taking the Pulse of the Public Mental Health System." A letter was sent to various constituency groups, asking them to comment on their perception of the unmet needs in the system; major public policy issues they see; and major public policy issues that they are working on.

Letters were sent mainly to mental health constituency groups for children, adults and older adults. Ms. Arneill-Py provided a summary of the results in a handout.

The following groups responded:

- NAMI
- The Network
- The California Foundation for Independent Living Centers
- The California Association of Caregiver Resource Centers
- Community Care (an older adult provider organization)
- Multipurpose Senior Service Program Site Association, Inc.
- The California Association of Public Authorities for In-Home Supportive Services

Basically what CMHPC had was a perspective from adult and older adult provider organizations. Ms. Arneill-Py's recommendation was to focus on children's and transitional age youth provider organizations for the next round of letters.

Ms. Arneill-Py did an analysis of the feedback received from the first round of letters. Highlights included:

- NAMI commented that there is a culture of fear throughout the public mental health system, at both the local and the statewide levels. Individuals are afraid of filing complaints for fear of losing their FSP services. NAMI affiliates who are receiving funding from the counties are afraid to complain for fear of retaliation, in terms of losing their funding. Generally, there's a fear of retaliation.
- There is concern about lack of private mental health insurance plans, and lack of adequate coverage of mental health and substance abuse disorders in private plans.
- There is concern about the issue resolution process from the network.
- The network was concerned about the MOU between the government partners.

- There were a number of comments from both NAMI and the network concerning stigma and discrimination in the public mental health system, the community in general, and the workplace. Ms. Arneill-Py's suggestion is to let the MHSA Stigma and Discrimination State-Wide Project focus on those issues.
- CMHPC received comments about issues related to integration of primary care and mental health care from both NAMI and the network. That is going to be the topic of the June Planning Council meeting.
- CMHPC received a number of comments that Ms. Arneill-Py would group under the topic of budget advocacy, including concerns about cuts to MediCal; progressively longer waits for services; client-run and self-help centers being closed; and seniors not receiving appropriate services.
- The California Foundation for Independent Living Centers submitted a comment on disability access. Unmet needs are primarily due to barriers in architecture; ineffective communication; administrative policy; lack of knowledge base of personnel administering and implementing services. The Human Resource Committee (HRC) is planning a major project to address these issues.

Mr. Brian Keefer, HRC, came forward at this point to brief the Council about this. He stated that HRC decided to create a project on looking at resources and information that can be provided for strategies to recruit and retain individuals from the broader disability community employment setting. HRC hopes to do a variety of focus groups, and hopes that it will lead to the development of a resource guide. HRC will be working with the California Foundation for Independent Living Centers on the project.

The next issues fall to the Adult System of Care Subcommittee. They include:

- The system lacks ways to empower clients to move towards more natural community supports, as they progress in their recovery.
- When clients choose to see a psychiatrist, appointments are too short and infrequent, preventing effective communication.
- Clients on problematic medications who need primary care are not being referred and given follow-up examinations or adequate information.
- There is a loss of navigation staff, when they are really needed more than ever because of loss of services.

- There is a lack of employment services, both inside and outside the mental health system. This is a critical problem because 85-90% of mental health clients are unemployed.
- There is a need for permanent, affordable housing, with or without supports.
- There is a concern about the loss of client-run programs, due primarily to the lack of revenue generation.
- There is concern about client employment in general.
- There is an issue about lack of informed consent on psychiatric medications, and corresponding lack of true shared decision-making.
- There is an issue of continued abuse, limited spaces, and poor conditions at state hospitals and IMDs. Both NAMI and the network raised issues about seclusion and restraints.
- The network is concerned about the promulgation of AB 1421 involuntary outpatient programs.
- There is a question of social justice and access to services and client employment in the mental health system.

The one issue for the Transition-Age Youth (TAY) Subcommittee is that TAY is falling through the cracks.

The Older Adult System of Care Subcommittee had a number of issues raised, because of the number of older adult constituency groups that commented.

- Issues related to the Mental Health Services Act (MHSA):
 - The older adult service system is vastly under-budgeted.
 - The MHSA emphasizes children and youth, which has led to ignoring the problem of suicide among the senior population.
- It's becoming common to attribute every senior citizen's mental health disorder to dementia or Alzheimer's disease.
- There is an increase of physicians prescribing for mental health conditions without any training in psychiatry or any cursory assessment, and physicians rarely referring clients to specialty mental health services.
- There is a need to establish mobile geriatric assessment teams in every county.
- There are issues around support for caregivers, and a corresponding need to increase support for the California Caregiver Resource Centers.

- When consumers of In-Home Supportive Services are diagnosed with a mental disorder, coupled with a neurologic disorder like traumatic brain injury or dementia, the mental health system is unable to provide adequate care for these clients, so that they can remain independent.

For the Cultural Competence Committee, both NAMI and the network raised some general points about the lack of sufficient cultural competency and linguistic services. There is a need to incorporate holistic services and culturally traditional healing arts in the array of service systems that are offered.

For the Human Resource Committee, the comments were not that extensive:

- There aren't enough psychiatrists.
- There is a need to do cross-training in co-occurring disorders, trauma informed care, and harm reduction.
- Not all providers are on board with recovery and forming an alliance with their clients, as opposed to expecting compliance.

For the Policy and System Development Committee, five issues were raised:

- Safe, permanent, affordable MHSA housing is still needed.
- PEI program funding is needed when we aren't providing effective and timely services and supports for existing clients, and none at all for some populations.
- A flexible funding proposal for system integration is needed.
- MHSA needs to be preserved with fidelity.
- Clients need to be involved in the stakeholder process.

The Planning Council had quite an extensive set of comments provided by the letters. This summary was Ms. Arneill-Py's recommendation for the dispensation of these issues among the committees.

Discussion

Ms. Thal: The CMHPC has a responsibility to follow up with the organizations that provided feedback. The Council should thank them for their original feedback and let them know that they have been referred to specific committees who will follow through with them.

Ms. Hart: Ms. Arneill-Py and I have made plans to go back to the groups that did not respond, and have added some groups, particularly for TAY, to obtain perspective from the youths themselves.

Mr. Bellotti: The Council should be aware that -- pertaining to the Adult Systems of Care Subcommittee about seclusion and restraints -- due to our current economic situation, the Office of the Legislative Analyst is proposing to repeal positive behavior intervention regulations that have been in place for school-age children for about 18 years. This was a result of untrained individuals creating negative incidents with the children. CMHPC should continue to monitor this situation, because it's not good for people accessing services in the system.

Ms. Benjamin: The California Caregiver Resource Centers are funded by DMH to address the needs of caregivers in the state. They have made a comment that in the past eight years funding has decreased by 10%, and that increasing support for their group would be a cost-effective and efficient method for supporting the mental health of California's family caregivers. Ms. Benjamin sees this as a budget-related issue that she'd like to have transferred over.

Ms. Benjamin: Supported the position of several Council members that much effort obviously went into the response letters, so adequate attention should be given to those who responded. She proposed that CMHPC revisit what the committees have done at a future full council meeting -- what actions are the committees recommending? Ms. Benjamin also proposed that CMHPC government partners -- the CMHDA, OAC, and DMH -- be included in the letter review process, to be processed through their structures.

Ms. Abbott: What is the CMHPC doing with the budget and with the general advocacy? Ms. Arneill-Py replied that the general advocacy basically comprised information for the group to be aware of. The budget advocacy issues are those that CMHPC tends to address in their letters, around the cuts that happen every year.

Ms. Abbott asked if Mr. Kingdon wanted to comment on the "culture of fear?" He responded that NAMI executives had indeed brought this issue to the attention of CMHDA. The Network and NAMI both attend CMHDA board meetings and discuss issues of concern. The outstanding issue is actually the issue resolution process.

Mr. Ryan agreed that it's quite necessary for feedback from the network to keep the CMHDA in touch with reality. He inquired whether this input will be solicited for every meeting. Ms. Arneill-Py wondered how long the CMHDA wants to continue this process. Discussion ensued on this point.

Ms. Becker stated her disappointment that the children's organizations were not represented in the responses. She also felt that any organization that is given money under the MHSA should be accountable to respond. She also recommended writing a thank-you letter to each network respondent. Regarding the term "family member," Ms.

Becker suggested that the CMHPC start to re-use the term “parent” in some of their language. Mr. Ryan suggested using the term “parent/caregiver.”

Ms. Cedro-Hament suggested adding the partners group for feedback requests, as they might have a different constituency and could then bring some new information.

Ms. Burke commented about fear in the mental health system: clients who complain fear retaliation. What can be done about it? Can clients be guided to legal aid? Ms. Chaiken agreed that this issue is an important one. She suggested that people who have experienced retaliation for making complaints share their knowledge in writing. The stories could then be shared when training mental health providers. Mr. Fry added that those clients have already been recording their stories and reporting them to the client network.

Ms. Mitchell felt that assigning issues to the committees is helpful, and gave an example of the issue of client-run self-help centers not producing MediCal revenue.

Mr. Walker shared suggestions he had on specific issues mentioned: cultural fear, the private mental health/parity bill, institutionalization of IMVs, CSS plan updates, and seclusion and restraints.

Chair Mueller then accepted comments and questions from the audience.

Guest Comment: In some counties, the administrations are threatened by CMHPC because CMHPC is verbal about things. It’s a big challenge to try to overcome. Also, the client network and SAMHSA sponsored a 4-day training for 23 people from up and down the state. They were trained on getting their voices heard. The trainees will go out to all the counties, helping consumers learn to advocate for themselves. The consumer’s final comment was that he doesn’t understand why people in power feel the need to tell consumers what to do; they only need to ask consumers what their needs and wants are.

Response from Eduardo Vega, ex-officio CMHPC, member of the Mental Health Services Oversight and Accountability Commission, and co-chair of the Client and Family Leadership Committee: This is important to the Client and Family Leadership Committee, in particular, for two reasons:

1. The committee is trying to respond to just this set of concerns.
2. At this point California’s mental health system is in the middle of transformation. MHSa is part of the fuel. But there is no single entity that has been willing to take a role in defining what the transformation should be.

Mr. Vega invited the Planning Council to take on the development of a Master Plan. In his advocacy role, Mr. Vega would like to end the practice of putting out fires and respond off the cuff; a broadscale plan is needed. He closed by inviting the Council to send a member to meetings of the Client and Family Leadership Committee.

Mr. Henning wanted everyone to know he would send this letter to OAC as soon as the meeting adjourned. He felt that the feedback contained in the letter is excellent, and that the Council needs to start looking at some of these issues.

Ms. Hart followed that the CMHPC hoped to receive more data from the children's groups and TAY; she hoped that it would also be included.

Ms. Alysa Solomon, a psychologist for LA County DMH, related a story in which her medical and psychiatric emergency was mishandled in Los Angeles hospitals, with her being placed in seclusion and restraint erroneously. She stressed that she wanted the seclusion and restraint issue to remain at the forefront.

Ms. Stacie Hiramoto, MHAC/REMHDCO, thanked the Planning Council for their work. She received CMHPC's feedback request letter while her department was working with the community partners on two crucial tasks. She apologized for not responding, and intended to send a late response. She then noted that the fear and retaliation issue among providers is present with REMHCDO members.

9. Adjournment

Chair Mueller adjourned the meeting at 5:45 p.m.

Friday, April 17, 2009

1. Welcome and Introductions

Chair Mueller called the meeting to order at 8:40 a.m. Planning Council members and guests in the audience introduced themselves.

Chair Mueller recognized one of the Planning Council members, Shama Chaiken. Ms. Chaiken was attending her last meeting as a member and she has been appreciated as a scholar, mentor, friend, and contributor. Ms. Chaiken thanked Chair Mueller for her recognition, and has felt great love and support from CMHPC and wants to remain connected.

2. Committee Action Items

Regarding the Vital Signs discussion from yesterday (4-16), Chair Mueller requested that the committee chairs bring pertinent information forward to their committees. The Council looks forward to hearing back, in committee reports or agendas, about the considerations that were shared.

John Ryan asked whether CMHPC would regularly invite various organizations to provide their perspectives, or if this was a one-time snapshot. Ms. Arneill-Py responded that CMHPC had a series of organizations that the Council could still contact in

succeeding months. Mr. Ryan suggested an open door policy for all meetings, whereby any organization with issues they consider important can attend and present concerns.

George Fry agreed with Mr. Ryan's sentiment, and suggested having an open forum slot on CMHPC meeting agendas. Beverly Abbott commented that she liked this meeting's format, and suggested sending a letter at intervals to follow up on Vital Signs. Ed Walker suggested that leadership come up with a common framework for the committees to respond to this, to promote consistency and follow-up.

The Cultural Competence Committee made two points.

1. For the CMHPC to send out cultural competence guidelines, formulated at a previous meeting, for meeting presenters to use.
2. The Cultural Competence Committee is working on two goals: Discussion of issues should be done on an intellectual level; and transformational/experiential exercises should be done at meetings.

The Policy and System Development Committee had one critical announcement: as part of the federal stimulus package, there's money available to most communities in the form of the Homelessness Prevention and Rapid Re-Housing Program, also referred to as HPRP. It's based on the number of foreclosures in a community. The turnaround time is extremely fast. Virtually everyone that the public mental health system provides services for would be eligible.

The Human Resources Committee had one action item: to do a SAMHSA disability project that would look at strategies to include the broader disability community within employment programs throughout California's public mental health system. The committee will present the project details for CMHPC to vote on in June.

3. Approval of the January 2009 Meeting Minutes

There was a requested change to the January 2009 Minutes: on page 2, fourth bullet down, Ms. Hudson requested that the minutes read "children aged 15 -17, adults and older adults."

Motion: The Minutes of the January 2009 Meeting were unanimously approved as submitted, with the exception of the amended number *17* rather than *18*, as noted above, which will be corrected at a later date.

4. Approval of the Executive Committee Report

The Council reviewed and approved the Minutes of the January 2009 Executive Committee Meeting. They reviewed the budget for expenditures 2008-09 and were on target. They also had discussion and public comments on the MOU. Ms. Arneill-Py summarized the points and the motion that was passed at the meeting.

The MOU between DMH, OAC, the Planning Council, and CMHDA: the Executive Committee originally reviewed the MOU and proposed several changes. Two were accepted and several weren't. The community partners then requested that the Executive Committee not act on the MOU at that time, as the community partners wanted more time to review that MOU and develop some alternatives to it. A motion was made to delay action on the MOU; a second component of the motion was that Executive Committee talk with DMH and restructure the stakeholder input process.

The Council discussed and clarified issues regarding full council approval of the MOU following Executive Committee approval.

Motion: The Executive Committee Report was unanimously approved as submitted.

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

James McGhee, CALMHBC President, presented an update of the past 90 days for CALMHBC, as well as future agendas. Mr. McGhee felt that the organization has made tremendous strides in the past year toward its commitment to serve the California consumers. Some highlights:

- They have been meeting on a regular basis.
- They had their first retreat, which resulted in a strategic plan.
- The Finance Committee completed an internal audit.
- Mr. McGhee applauded the Treasurer, Ms. Susan Wilson, for taking leadership to organize the finances of CALMHBC.
- The first Vice President, Dr. Kimberly Kennard, has taken the responsibility to work with all the regional coordinators. They are now holding their regional meetings prior to the board meetings.
- Dr. Kennard has also taken on responsibility for handling all the board member registration with the hotels. This has saved money for CALMHBC in not having to pay for late cancellations.
- The second Vice President, Ms. Charmaine Quinlan, has been working with the committee chairs to make sure that the committees put together their agenda items.

Mr. McGhee then gave highlights of CALMHBC's 2009-10 strategic plan.

Last, Mr. McGhee stated CALMHBC had decided to move forward with its June conference, in spite of the current economic climate. He noted with enthusiasm the scheduled speakers and workshop facilitators. He invited all CMHPC members to attend.

Ms. Hart and Mr. Fry commended Mr. McGhee and the committee members for the activities they are accomplishing. He requested Mr. McGhee to send his presentation minutes in advance of the Planning Council's meetings, which Mr. McGhee agreed to. Mr. McGhee noted that CALMHBC now has a website: www.calmhbc.net or www.calmhb.net

Mr. Ryan asked whether Mr. McGhee sees fewer homeless mentally ill people on the streets than he did before MHSA. Mr. McGhee's response was, "Not really." It's still a major problem, it's just spreading out a little throughout the city, and is no longer concentrated in "sore sight" areas.

Ms. Cedro-Hament inquired whether the counties have paid their \$300 CALMH Board yearly dues. Ms. Wilson, the Treasurer, replied that the CALMH Board is certainly keeping track, and so far this year 28 counties have paid.

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

Ms. Sheri Whitt of the MHSOAC thanked the Planning Council for the invitation to come and speak. She stated that the MHSOAC contains five committees that operate within the Commission. The committees consist of commissioners, staff, and stakeholders. Their agendas and materials are always posted on the website; in addition, meetings are open to the public.

Ms. Whitt summarized the five committees.

- **The Funding and Policy Committee** is working on a report template, which will establish specific activities that the committee does to assist the commission in oversight and accountability with respect to MHSA funds.
- **The Evaluation Committee** is responsible for conducting global assessment of the transformation of the community-based mental health system. It is preparing to launch a large evaluation project.
- **The Client & Family Leadership Committee** is charged with monitoring and reporting back on the stigma and discrimination reduction strategic plan. It also ensures that the perspective of clients and family members is considered by the Commission in all of its decision-making.
- **The Cultural and Linguistic Competence Committee** is completing a paper on disparities in access to and quality of services for individuals living in racial, ethnic, and cultural communities. They will be monitoring the

Reducing Disparities and Suicide Prevention statewide projects. It is also developing training for the staff and the Commission with respect to cultural competence.

- **The Services Committee** primarily oversees all activity having to do with plan review, comment, and approval. It is also developing a series of summary reports, designed to serve as a way of transmitting lessons learned as a result of this plan review process back to the Commission.

In addition, a Communications unit has the primary role of ensuring transparency of activities related to the implementation of the MHSA and the Commission. They have been doing a number of press releases around approval of PEI plans, as well as special project press releases.

Ms. Whitt shared some of the goals being proposed in the MHSOAC Strategic Plan:

- Define transformation and articulate its vision.
- Develop an integrated, consistent approach to evaluate the results of the MHSA, and facilitate the adoption of best practices across the entire community-based mental health system.
- Adopt an approach for significantly reducing forms of mental health stigma and resulting discrimination.
- Further refine the roles and responsibilities of the Commission.
- Adopt an approach for reducing disparities in access to and quality of services for racial, ethnic, and cultural communities.

Ms. Whitt stated that the Communications unit has been very busy creating materials to help the community at large in understanding how they can get involved at the local and state levels.

7. Proposed Mental Health Services Act Issue Resolution Process

Mr. Walter Shwe and Ms. Ann Arneill-Py represented the CMHPC in the development of this proposed Issue Resolution Process. They gave a PowerPoint presentation on this topic. Highlights include:

- The Issue Resolution Workgroup was formed because Welfare and Institutions Code Section 5845(d)(7) states that MHSOAC is supposed to refer critical issues to DMH. MHSOAC and CMHPC have received issues from stakeholders about MHSA issues, and have referred those to DMH.

- After issues started being referred to DMH, the groups involved decided to form a workgroup to develop a process of how to best handle the incoming issues. The workgroup consisted of MHSOAC, CMHPC, DMH, and CMHDA.
- DMH had basically been using this process because none existed before. The process had been given a public review period before becoming final. DMH put on a webcast/conference call to accept public input.
- The WIC 5845(d)(7) states that when the OAC finds critical issues related to county mental health programs, they are to refer them on to DMH.
- WIC 5655 gives the actions that the Director of DMH can take if he/she finds that any county had failed to comply with regulations.
- Responsibilities of CMHPC were codified in WIC 5772(b) and (d).
- A brief outline of the Issue Resolution Process for the counties was shown. Counties must comply with all regulations and at the same time ensure accountability and use strategies that best meet the needs of their communities.
- MHSA issues are submitted to MHSOAC, CMHPC, and DMH. Non-MHSA issues are referred to other resources.
- A summary of public comment received to date was provided. It came from three venues: the MHSOAC meeting on 3/26, DMH Webinar on 4/2, the Client and Family Member Leadership Committee on 4/6. One of the major concerns was the Issue Resolution Process itself.

Public Comment

- *Stacie Hiramoto*, MHSA Community Partners, thanked Ms. Arneill-Py and Mr. Shwe for the presentation and for enumerating the concerns of the community. She said that statewide stakeholders would have liked to be involved from the start in development of the Issue Resolution Process. They appreciate the opportunity to give public testimony and comment until May 31; they want a seamless, easy-to-follow process and don't feel that it is user-friendly now.
- *Vernon Montoya*, CNMHC/CARES Coalition. Mr. Montoya stated that he and his colleagues agree with the letter sent to CMHPC from the Community Partners, voicing concern over the absence of consumers and client advocates during the development of the Issue Resolution Process. Mr. Montoya stressed that they should have been brought to the table at the outset. He asked for the full support of the CMHPC in the current participation of the local entities. The CMHA process needs to represent stakeholders

- *Richard Hays* presented two handouts. One stated that a major reason for why clients and client families in San Diego County are not involved with program planning and implementation process is that the Board of Supervisors has a secret agreement with UCSD. He was unable to purchase a copy of the agreement, being told it was a private document.

The other document was a memorandum. Mr. Hays had a complaint that he brought to the local Mental Health Director, who directed Mr. Hays to take the complaint to the county complaint attorney. This official sent Mr. Hays the memorandum, which stated that he had no claim, and that he should hire a lawyer and file a lawsuit. That wasn't problem-solving; that was a threat. Mr. Hays then cited several legal problems:

- California law 5604.2 requires the DMH to involve clients in program planning. The Issue Resolution Process development didn't comply.
- The California Constitution states that there is no government agency (e.g., the DMH) that can administer its own grievance process.
- State Regulations 53297-99 state that no local agency official can take a reprisal action against any employee or applicant who files a complaint.

Mr. Hays concluded by describing a final problem: the San Diego Mental Health Director has consistently refused to register the activities of mental health boards, councils, and committees with the County Court Clerk. This meant that they didn't exist.

- *Robert Carter*, Client Advocate for the Client Coalition and the Network in L.A. County, commented on the stakeholder process. He was concerned that clients are not given enough time at stakeholder meetings to speak about their concerns; one minute or three minutes are not enough.

Mr. Fry commented that the slideshow presentation said the OAC *may* refer issues to DMH. This provides too much wiggle room; he felt strongly that the word should be *shall*. He also asked if there were whistleblower protections within the Issue Resolution Process.

Ms. Cedro-Hament had several questions. First, who within DMH will look into the cases? Second, what is the turnaround time for Issue Filers? Third, what is the Planning Council's role in the Issue Resolution Process?

Mr. Mortz had a question about grievances or complaints regarding MHSA only – would it be effective also to have copies of grievance procedures for non-MHSA complaints currently on the table? Are we building a two-tier system? Ms. Cabrera answered for MHSA: the MediCal grievance is in regulation, and that's what DMH follows. DMH can provide Title IX regulations for the conference call.

Mr. Vega stated that the Client/Family Leadership Committee had the charge to review the Issue Resolution Process for the OAC. They will present their report at their May meeting. He noted that it is unclear which entity within DMH is responsible for providing unbiased oversight; and also, what if the concern is about DMH itself?

Chair Mueller noted that sometimes in the formation of action, there are more questions than there are answers. She thanked everyone for bringing forward their questions, requests for materials, etc.

8. Public Comment

- Charles Porter, United Coalition East Prevention Project and L.A. County Steering Committee for PEI, presented concerns about the prevention process he participates in:
 1. Understanding of prevention and limited range of options in prevention services. The services do not include prevention programs with a community-building model or coalition model.
 2. Regarding the issue of prevention, disparity is a benchmark for prioritizing prevention services. Comparing the general African-American population with the Skid Row population in downtown L.A. of homeless and mentally ill, you see a great disparity. It's a benchmark for priority in preventing mental illness.
 3. Regarding cultural competency in communities and neighborhoods: a theme is cultural empowerment, where they partner with non-traditional groups, as well as working experts on cultural issues. The effort is to look at addressing social systems. Services may be brought in that aren't necessarily mental health services.
 4. Regarding working with African-American community mental health issues: Two giants in the field that we haven't taken advantage of are Dr. Cheryl Grills, Chair of Psychology at Loyola-Marymount, and Dr. Wade Nobles of the Association of Black Psychologists. Their work should be included in any discussion of prevention.
- Dr. Perry Turner, CALMHBC, addressed a perennial problem that affects the Association of Boards, resulting from misapplication of the Brown Act. This act protects the right and will of the people to know how their sovereign business is conducted, in the context of quasi-legislative and legislative powers. The Association exercises no sovereign power, period. Within the Association, a fear of trying to do anything in between the quarterly meetings is stifling, and causes directors sometimes to question their own caring in what's going on. It can be terribly frustrating. The Planning Council needs to understand this, within the broad purview of its own role, in oversight and coordination of the entire state apparatus.

Two other points:

1. The Association of Boards is set to revise its by-laws. The Planning Council will receive a copy of the proposed revisions.
2. The website is also being revised. Dr. Turner invited the Planning Council to view it and submit their comments.

9. Cultural Competence Training: World View Exercise

Shama Chaiken conducted the training, which CMHPC members and the audience participated in. Its purpose was to look at cultural influences on the members' values and beliefs, based on groups that they affiliate with.

10. New Business

George Fry stated that it's high time that they have a consumer in Washington D.C. and announced that Dan Fisher is being considered for the position of head of SAMHSA. He is a consumer of 30-odd years and was on the President's Commission on Mental Health. Mr. Fry requested the Planning Council e-mail senators and Robert Gibbs at the White House, in support of Mr. Fisher.

Celeste Hunter recommended having some kind of record of the people who have served on the CMHPC. George Fry agreed, saying he had also brought up this idea at the Executive Committee meeting.

Joe Mortz asked whether it is appropriate for the Planning Council to make policy statements regarding universal health care and the reform of health care systems in the nation and in California.

Ed Walker asked for the staff and Executive Committee leadership to prepare a briefing on the Health Parity Bill.

Adrienne Cedro-Hament asked when the Planning Council was organized. Ann Arneill-Py answered that in 1993 the CMHPC was established as part of a task force, created post-realignment to determine the best vehicle for public input. Don Richardson was the first chair; people from the advocacy community influenced the CMHPC. A historical record would be nice to have.

11. Adjournment

Chair Mueller adjourned the meeting at 12:25 p.m.