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State of California

**MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting  
May 23, 2013

Citizen Hotel  
926 J Street  
Sacramento, California 95814  
866-817-6550; Code 3190377

**Members Participating**

Richard Van Horn, Chairperson  
David Pating, M.D., Vice Chairman  
Sheriff William Brown  
Victor Carrion, M.D.  
Senator Lou Correa  
David Gordon  
Paul Keith, M.D.  
Assemblymember Bonnie Lowenthal  
LeeAnne Mallel  
Larry Poaster, Ph.D.

**Members Absent**

Ralph Nelson, Jr., M.D.  
Andrew Poat  
Tina Wooton

**Staff Present**

Sherri Gauger, Executive Director  
Aaron Carruthers, Chief Deputy Executive Director  
Kevin Hoffman, Deputy Executive Director  
Filomena Yeroshek, Chief Counsel  
Renay Bradley, Director of Research and Evaluation  
Norma Pate, Administrative Chief  
Jose Oseguera, Committee Operations Chief  
Kristal Carter, Staff Services Analyst  
Cody Scott, Office Technician

**1. CALL TO ORDER/ROLL CALL**

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:45 a.m. and welcomed everyone. Administrative Chief Norma Pate called the roll and confirmed the presence of a quorum.

Chairperson’s Remarks

Chairman Van Horn introduced new governor appointee Paul Keith, M.D. Commissioner Keith has been medical director of behavioral health at the Wellpoint West Region of Anthem Blue Cross since 2000,

and medical director for integrated behavioral health since 1992. Previously, he was medical director of the Behavioral Health Unit at Palomar Medical Center from 2000 to 2009, associate medical director of the public sector program at United Behavioral Health from 1997 to 1999, medical director at Vista San Diego Center, medical director of the child and adolescent program at Alvarado Parkway Institute from 1987 to 1994, and owner and proprietor of Paul R. Keith, M.D., a Medical Corporation from 1975 to 2009. He earned a Doctor of Medicine degree from Baylor College of Medicine. Commissioner Keith holds the seat of the representative of a health care services plan or insurer.

**2. APPROVAL OF MARCH 28, 2013, MHSOAC MEETING MINUTES and APRIL 25, 2013, MHSOAC TELECONFERENCE MINUTES (ACTION)  
MAY – JULY 2013 MHSOAC CALENDAR  
MAY 2013 MHSOAC DASHBOARD**

Commissioner Brown stated that the last sentence in the third full paragraph on page 8 of the March 28, 2013 minutes should read, “state government” instead of “federal government.”

**Action:** Vice Chairman Pating made a motion, seconded by Commissioner Carrion that:

*The Commission approves the March 28, 2013, MHSOAC Meeting Minutes as amended and the April 25, 2013, MHSOAC Teleconference Minutes.*

- Motion carried, 9-0

**3. FINANCIAL UPDATE**

**A. Overview of Governor’s Revised Budget for Fiscal Year (FY) 2013-14 and Related Budget Proposals**

Kiyomi Burchill

Kiyomi Burchill, Assistant Secretary of the California Health and Human Services Agency (CHHS), provided an overview of the May revision to the state budget and some of the key points as they relate to mental health. The May revision to the state budget included \$1 million in funding for implementation of the Commission’s Evaluation Master Plan.

Ms. Burchill’s overview focused on the governor’s proposal on Health Care Reform (HCR) in the May revision, regarding the Medi-Cal program. In January, the governor’s budget proposed to continue implementation of federal HCR and outlined a number of principles for that implementation in California:

- It must be sustainable and affordable.
- It must fairly allocate risk and fairly delineate roles and responsibilities between the state and the counties.
- It must maintain a strong public safety net.
- It must support local flexibility.

The May revision proposes a state-based approach for expansion. Newly eligible individuals will receive the comprehensive benefits currently provided by Medi-Cal, including county-administered specialty mental health and county-supported substance use disorder services (SUDs) through the Drug Medi-Cal

Program. Long-term services will be covered, provided the federal government approves the retention of an asset test for those services.

Under HCR, county costs and responsibilities for indigent health care are expected to decrease. The state will bear the financial cost and risk of expanding coverage to those currently uninsured adults. There is much uncertainty about how many people will enroll, where they will receive care, and what costs associated with services provided to uninsured individuals will remain. Counties play a key role in providing access to and delivery of health care services to both Medi-Cal beneficiaries and the uninsured. Preserving a strong public safety net is a priority.

Given these factors, the May revision proposes to establish a mechanism to determine county health care savings based on actual experience. As the state resumes greater financial responsibility for health care coverage, there will be an expansion in the counties' role in human services programs.

Counties will realize savings in mental health as a result of the Medi-Cal expansion. Currently, counties incur the costs for mental health services for individuals who are medically indigent, which are estimated at \$400 million annually. Counties use multiple sources of funding, including Proposition 63 Mental Health Services Act (MHSA) and 1991 Realignment funds, to cover the costs of this care. It is likely that a significant percentage of these medically indigent individuals will become eligible for Medi-Cal specialty mental health. This will allow counties to cover those costs with 100% federal funding beginning in 2014 and going down to 90% of the funding by 2020.

A good investment of this savings is in the expansion for specialty mental health and SUDs. In SUDs, as with mental health, CHHS is proposing the current benefit and delivery system layered with an enhanced SUDs benefit that counties could opt-in to provide services. There is greater treatment success when individuals can enter a continuum of services at the level that meets their needs, which serves to improve overall health and public safety goals, resulting in reductions in supervision, violations, and offenses that lead to incarceration. If counties opt-in, they would agree to pay the non-federal share of these benefits. Specific funding would be made available to counties as an incentive to opt-in. The estimated cost would vary depending on what the enhanced SUDs benefit package includes.

Based on previously-received recommendations for enhanced benefits from counties and from other stakeholders in SUDs field, the Department of Health Care Services (DHCS) is specifically considering five potential enhanced SUDs benefits: intensive outpatient treatment, residential treatment, recovery supports, opioid detoxification, and alcohol detoxification. This is outlined in a paper, released Tuesday, by DHCS. They will engage in a discussion with counties and stakeholders about the enhanced SUDs benefits, in terms of what an enhanced package could include. Ms. Burchill will provide Commissioners with a link to that paper.

The implementation of HCR is a historic time in California. It is critical that progress for the individuals in need of health care be done in a thoughtful, sustainable manner.

#### **Commissioner Questions and Discussion:**

Commissioner Carrion stated that there was concern that children who receive services through Healthy Families, specifically children with autism, may lose some of those services when they shift to Medi-Cal,

and asked if the expansion would cover this. Ms. Burchill answered that the May revision proposals are separate from the benefit package for Healthy Families. She offered to gather more information on this.

Chairman Van Horn cautioned that changes in substance abuse treatment could potentially eliminate coverage for some individuals, as pointed out in a correspondence between state Medicaid directors and Vanessa Baird. In response to this point, Ms. Baird wrote that, when the state carves out mental health for SUDs from its managed care plans, the parity requirement no longer applies.

Ms. Burchill agreed that the guidance from the federal government indicates that those with a separate plan for mental health are not subject to parity, but are encouraged to apply those principles and values. The expansion proposes the current specialty mental health benefits – which include such cornerstones as rehabilitation, day treatment, and crisis stabilization – be maintained and made available to the expansion population. CHHS has also proposed more robust SUDs benefits to provide a continuum of treatment, which counties can opt-in to.

Chairman Van Horn noted that counties' ability to opt-in or not could result in widely variant standards of care around the state.

Commissioner Poaster stated that, within the county mental health programs, they provide a 50% match. He asked if they will continue to match Medicaid dollars under the plan. Ms. Burchill answered that they will for those who are in the existing population. It is only the expansion population that will be eligible for the enhanced federal reimbursement of 100% in 2014.

Commissioner Poaster asked if a county's expansion of SUDs benefits will be 100% reimbursable under Medicaid. Ms. Burchill answered that they would all be eligible for Medicaid reimbursement through Drug Medi-Cal. CHHS proposal is that the enhanced benefit be provided for both those who are eligible and have the currently-limited Drug Medi-Cal benefit, and those who will come in through the expansion population, so that everyone will receive the same benefits package. For the existing Drug Medi-Cal population, the federal reimbursement is 50%. For the expansion population, people who will become eligible for Medi-Cal after January 2014, the federal reimbursement is at the enhanced benefit level of 100% for the first three years.

Commissioner Correa cautioned that the issue will not be between conservative and progressive counties; the issue will be finances. Many counties are still reeling from the economic downturn and will have to make difficult decisions. Any guidance to help bring more uniform application throughout the state would be good policy.

#### Carla Castañeda

Carla Castañeda, Principal Program Budget Analyst of the California Department of Finance (DOF), provided an overview of the revenues and what DOF has approved in the May revision for expenditures.

The revenues are 1% on income over a million dollars, so it is a volatile source of income. In March, DOF notified the Legislature that the past year's Revenue Annual Adjustment was lower than estimated in the governor's budget by \$124 million. At the May revision, for the current Fiscal Year (FY) 2012-13, the total revenue has increased by \$78 million and the budget year's revenues are assumed to be \$63 million lower. That decrease in the budget year results in the reduced administrative cap, which is

3.5% of the revenues. Based on the proposed expenditures in the May revision, the current total is approximately \$1.5 million over that cap; but, given the volatility of these revenues, if the governor's budget does not increase, DOF proposes reductions in the then-current year. The increase would need to be \$43 million.

The May revision includes reappropriations of Workforce Education and Training (WET) program funds for the Office of Statewide Health Planning and Development (OSHPD). Most of that is from prior years, where the authority had expired for the department to expend. There is an additional reappropriation for the funds that are about to expire to continue those reappropriations for the life of the current plan.

The only statewide administration adjustment was for the Commission to provide six positions and \$300,000 for contract funding to begin implementation of the Evaluation Master plan.

#### **Commissioner Questions:**

Commissioner Poaster asked which estimate is more accurate, the one from the governor or the Legislative Analyst's Office (LAO). Ms. Castañeda answered that DOF estimate is more conservative and assumes the recent uptake in revenues is more one-time. LAO estimates a more optimistic increase. They will not know for certain until later in the year.

#### Diane Van Maren

Diane Van Maren, Principal consultant to Senate President pro Tem Darrell Steinberg, stated that she will address three areas, due to the discussion this morning regarding the Medicaid expansion and the administration's May revision:

- The Medi-Cal expansion proceeding through the Legislature
- The autism issue raised by Commissioner Carrion
- The mental health investment proposal of Senator Steinberg

There are two bills which are moving in special session:

- Assembly Bill (AB) X1 1, which was introduced in the California Assembly by Speaker John A. Perez.
- Senate Bill (SB) X1 1, which was introduced in the California Senate by Senator Ed Hernandez, and Senate President pro Tem Darrell Steinberg.

The two houses are working collaboratively; the two bills are identical and will be contingent upon each other for passage.

The Legislature is discussing a wide variety of issues, including the benefits package, which intersects with the administration's May revision. In the benefits package in the Legislative session, the traditional Medi-Cal benefit is included along with the essential health benefits (EHB), which is the Kaiser Small Group Benefit Plan. The individual market bills, which establish qualified health plans within the exchange, identified the Kaiser Small Group Benefit Plan for California's EHB to meet with federal Affordable Care Act (ACA) requirements. What this will mean for both the traditional Medi-Cal population and the expansion population is all of the existing Medi-Cal benefits would be included in addition to EHB, which are different from Medi-Cal, such as SUDs, autism services, and a few more focused services including some occupational therapies.

The Medi-Cal expansion embraces the intent of the federal ACA, addresses the parity issues, and provides increased accountability to managed care plans. Savings will be realized when individuals and their SUDs are appropriately managed. It is also a more comprehensive way to treat the whole person and have accountability. There are differences of opinion with the administration on how to approach the benefits package within Medi-Cal.

Another core issue with respect to the autism benefit is that the Legislature was disappointed to learn that Healthy Families children were being dropped from their applied behavior therapy for autism treatment when they were transitioning to Medi-Cal. That clearly was not the intent of the Legislature's agreement to transition children from Healthy Families to Medi-Cal. Senator Steinberg sent a letter to Secretary Dooley in November 2012, requesting follow-up and requesting the administration find a temporary solution until a longer-term solution could be found. Unfortunately, that has not fully materialized. Senator Steinberg is coming forward with a proposal in today's Senate Subcommittee 3 Budget Hearing to fund autism services within the Medi-Cal program to ensure a comprehensive benefit is provided and to right a wrong that should not have occurred.

Ms. Van Maren referenced a seven-page outline of a comprehensive proposal by Senator Steinberg.

The proposal recognizes that California has a community capacity issue: it needs to have more capacity for crisis mental health services, crisis stabilization, and mobile crisis teams in the community in order to mitigate inappropriate and unnecessary hospitalizations and to provide more comprehensive care for individuals in a community-based setting for the treatment of mental health issues.

Ms. Van Maren directed Commissioners to Point A on page 2 of Senator Steinberg's letter, "Enrollment in Coverage and Triage Case Management Assistance." One of the key Medi-Cal expansions is to the new childless adult population. It is anticipated that there will be a high percentage, possibly as high as 30%, of these newer individuals with some mental health and SUDs needs. The first call to action is to bring people into coverage. The expansion legislation will provide additional opportunities for this. There will be language that will provide for hospital presumptive eligibility based upon certain basic criteria.

The California Endowment approved \$26 million for outreach assistance. The Legislature took budget committee action to bring those funds into the budget process so that those dollars could be matched with federal funds for a comprehensive pool of \$52 million. Those funds will be used to enroll people into Medi-Cal and to create a grant program. The grant program will be focused on special populations, such as individuals with mental health needs, homeless, or African-American men who have not been enrolled in Medi-Cal and who oftentimes need services and assistance. The focus will be to bring people into coverage and to urge enrollment.

It is important to then facilitate people and their usage of health care services. There are many terms used here, such as "targeted case management" or "navigators." Senator Steinberg prefers the term "triage personnel." There has been discussion in California, specifically in Sacramento, due to the inappropriate "patient dumping" of a hospital in Nevada. People need to know where to go to access mental health treatment and other social services. Senator Steinberg believes it is important to have triage personnel to bring people into coverage and to navigate that coverage. An individual with significant mental health needs frequently has some social services needs, housing needs, potentially

medical needs, etc. Triage personnel would be able to provide additional staffing based upon needs that are then identified by counties and by communities for assistance.

Ms. Van Maren directed Commissioners to Point B on page 4 of Senator Steinberg's letter, "Expand Network Capacity for Continuum of Care." It is well-recognized that additional residential capacity is necessary. California has experienced a reduction of at least 3,000 psychiatric beds over the last several years, and there have not been any program startup funds or capitalization funds provided for programs. MHSA housing has been very successful, but a fuller continuum of care is crucial.

The concept would be to provide \$142 million in a one-time general fund to build capacity by at least 2,000 beds for residential crisis units and to fund twenty-five mobile crisis teams. This capacity building will be based upon a grant program and will be operated through the California Health Facilities Financing Authority (CHFFA), a department under the state treasurer's office with experience in creating this type of grant. There would be a competitive process across different regions of the state. Trailer bill language will be needed, and collaboration on the design of that language is important. It is also important to have services provided in rural, suburban, and urban areas.

Another key component is peer support and peer training. There are research and reports that show that the use of peers is effective. It is important to provide crisis management training and suicide prevention training, and to professionalize peer counselors and peer support to be used as part of the triage teams and to be more comprehensively involved in crisis residential services.

Ms. Van Maren directed Commissioners to Point C on page 6 of Senator Steinberg's letter, "Linkage with Public Safety Realignment." There has been quite a bit of discussion regarding AB 109 and the transition of individuals from prison and jail settings into the community. Providing these additional services will also help facilitate reentry and recovery to reduce recidivism and homelessness of this population.

SB 364, which is Senator Steinberg's legislation, proposes changes to Section 5150 of the Lanterman-Petris-Short (LPS) Act or involuntary commitment. This legislation has not been reviewed in over forty-five years. It is always a difficult topic of conversation for those involved in the mental health treatment world. The intent is to more fully recognize how treatment has evolved. Voluntary services must be expanded. The 5150 process is not consistent in procedures throughout the state. The intent is to provide approximately \$400,000 in funds, and to develop consensus guidelines and training, including bringing in peace officers and the full continuum of professional personnel, to provide more consistent application of Section 5150 and to have a clearer understanding of how that process works.

Proposition 63 had provided 5% of the overall revenues for state administration in the original proposition. Two years ago, that 5% was reduced to 3.5% of the revenues because of transitioning into an operations/implementations mode. Currently, any unexpended funds from the state administration go directly to the counties for expenditure and local assistance.

What this proposes to do is to revert back to the original intent of Proposition 63 and to use a 5% state administrative percentage, which provides \$46 million in MHSA funds between the current year and the budget year that would be available for expenditure. The difference between 3.5% and 5% would be reinvested to build capacity and used to hire around 600 triage personnel, assuming that 40% of the

personnel would also be eligible for a Medicaid match, because most of these cases would be targeted case management.

\$2 million of MHSA funds would be used for peer support training, and around \$400,000 would be used for the consensus guidelines. Another portion of funds would be used to staff the twenty-five mobile crisis support teams, assuming a minimum of three staff per team. Counties will be able to hire additional staff or have a different configuration. All of these service capacity constructs are Medi-Cal reimbursable because, with this expansion population, 100% federal funds can be brought down for the first three years. Because of how realignment works, counties will also have expanded costs for their existing Medi-Cal population that will be staying on services longer. The proposal aims to provide some additional funds for building capacity.

Senator Steinberg's office is actively seeking the participation of the Commission in the determination of the triage personnel and the consensus guidelines for the involuntary commitment.

#### **Commissioner Questions and Discussion:**

Commissioner Brown asked if the funding will be used to create mobile crisis support teams in counties that have none, or to augment teams that could operate under the proposed model.

Ms. Van Maren answered that the funds can be used both ways. Because of the geography of California and the regionalization of medical services, counties may have existing mobile crisis support teams but require additional capacity to serve other regions. Some of this could be addressed on a more collaborative regional basis across several counties. There will be a framework, but counties will have flexibility to come forward as part of the proposal process.

Commissioner Brown referenced the additional capacity-building funds and asked if those would be one-time or an ongoing amount of money used to sustain emerging programs.

Ms. Van Maren answered that the capital outlay of \$142 million in general funding is one-time. MHSA funds for state administration are ongoing, except for the guidelines. The triage and mobile crisis team personnel would be ongoing. The construct is to use and leverage those federal dollars. All of those aspects are federally reimbursable. Peer support is federally reimbursable in eight counties, but the state is working to have certification for peer support statewide in the next year.

Commissioner Keith asked if criteria for modifying the outpatient services (OPS) rules already exists and, specifically, if there is any consideration of expanding this to mandated involuntary outpatient treatment.

Ms. Van Maren answered that her understanding is that there are some best practices being used regionally. The idea behind the development of guidelines is to identify those best practices and to develop a stakeholder consensus regarding involuntary commitment. The intent was to address Section 5150, but outpatient settings could also be addressed as part of that conversation. It is an area of need that has been overlooked.

Commissioner Keith emphasized the importance of the stakeholders involved in this process being experienced and familiar with the operation of the 5150, in order for results to be meaningful and useful for modifying the application criteria.

Commissioner Poaster asked if the administrative action required in the implementation will be through DHCS.

Ms. Van Maren stated that there is a \$500,000 placeholder. A lot of the work will be done by the state treasurer's office, the CHFFA, with respect to the crisis residential treatment capacity, the follow-through on the twenty-five mobile crisis teams, and the crisis stabilization units. Senator Steinberg's office would like the Commission to put the 600 triage personnel in place through a request for application process, and serve as a fiscal agent for the guidelines. Ms. Van Maren added that the Commission's work through evaluation and analysis has been instrumental in that Senator Steinberg values the Commission. A non-profit statewide entity involved in county community-based projects would be likely to follow up on the guidelines, such as California Institute for Mental Health (CiMH). DHCS is not involved in the proposal

#### Patricia Ryan

Patricia Ryan, Executive Director of the California Mental Health Directors Association (CMHDA), stated that the proposal is complicated regarding SUDs and mental health. Even though CMHDA has proposed that the Medicaid expansion benefits for mental health be consistent with the current Medi-Cal mental health specialty benefits, which are covered under the rehabilitation option, they are opposed to the governor's proposal that counties assume the state share of the cost after the 100% federal share ceases. CMHDA believes it is a violation of Proposition 30, wherein voters passed the revenue source to help pay for the realignment of programs including Medi-Cal specialty mental health and Drug Medi-Cal. Along with that, there are Constitutional protections that said that any programs beyond what the responsibilities were at the time that the initiative passed would have to be acknowledged by the state in some way.

Specifically, the Constitution states that legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs of levels of service mandated by the 2011 Realignment legislation, shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. It is the state's role and responsibility to pay for Medicaid expansion. The state is assuming that counties will have savings over time because they will have 100% coverage for some people who are currently uninsured.

What is not part of the proposal is acknowledgment that, with the expanded eligibility process and using the governor's figures for how many new enrollees will be found eligible for the current benefits, it is estimated there will be 40,000 new beneficiaries coming into the system who will be eligible for the current benefits and the current 50% match, not the 100% match. The administration is asking for significantly more money to help them pay for the non-mental health and SUDs beneficiaries in the state budget, but there is no acknowledgement in the state budget or any of the proposals that have come from the administration that counties, under the 2011 Realignment, are going to be absorbing these new beneficiaries at a 50% cost.

The administration also assumes the 10% match three years down the line, when that decision does not have to be made yet. As with the negotiations between counties and the state about what the actual savings will be with Medicaid expansion on a county-by-county basis, CMHDA believes the same

principle should apply to mental health and SUDs benefits. The mandatory population and what the actual savings might be for counties on a county-by-county basis must be taken into consideration.

Also, the administration assumes that, with the new Medi-Cal expansion eligibles, the current costs for counties for that population that are not covered now will be fully covered as of 2014. That is not the case for mental health. Many of the unmatched costs, or indigent costs, that counties incur now are paid for by Proposition 63. Many of those services are not Medi-Cal billable, and the Medicaid institutions for mental disease exception means that people who are Medi-Cal eligible and require hospitalization in what is considered an institution for mental disease (IMD) are not eligible to get a federal match. Regardless of whether they are eligible under the Medicaid expansion at 100%, cost will not be covered for people in IMDs.

There are many complexities associated with the mental health portion of the governor's proposal that need to be delved into to ensure the impact on county mental health is understood before assumptions are made about what counties should pay for three years down the line.

With regard to SUDs benefit, CMHDA has questions and concerns. CMHDA is working with their sister agency, the County Alcohol and Drug Program Administrators Association of California (CADPAAC), and with the California State Association of Counties (CSAC) to identify some of those issues. As with mental health, the proposal expects counties to assume the 10% share of cost for substance use. Counties will also have the option to choose from an array of benefits, and will have to provide those services to the current Medi-Cal population with a 50% match. If counties expand the benefits, they must pay for the current population and the expansion benefits. It is not clear where those funds will come from. The 2011 Realignment funding is intended to pay for the benefits that were in place for the population as of 2011; it will not cover any expanded benefits for the new population, or even for the current population.

CMHDA has the same questions about statewide standards. Ms. Ryan questioned the state's federal authority to allow counties to provide different levels of benefits. The governor's proposal gives counties the ability to better manage SUDs benefits, but has not provided any details of that process. The proposal also suggests that there would be incentive funds provided to counties, but no details have been provided about what those incentive funds would be, where they would come from, or how they would work.

CMHDA is in the process of reviewing the proposal and identifying questions and concerns to be shared with the administration. CMHDA believes that there will be some savings over time, but the metrics for those savings should be developed on a county-by-county basis and compared to the increased costs realized in other areas.

#### **Commissioner Questions and Discussion:**

Vice Chairman Pating stated that the expansion population is expected to be two to four times the rate of current mental health and substance abuse population. Existing assumptions for this expansion group need to be changed.

Ms. Ryan stated that the issue is more relevant to substance use. Many of those people are going to be coming in under the expansion population criteria and will probably have a disproportionate need for SUDs benefits.

Commissioner Poaster asked Ms. Ryan to comment on Senator Steinberg's proposal.

Ms. Ryan stated that CMHDA is supportive of Senator Steinberg's desire to provide crisis response services at the local level, but is concerned about going from 3.5% to 5% administrative cost to help pay for it, because money that is not spent at the state level goes to counties for services. This seems like more of a short-term program, but if going to 5% is ongoing, there will be less money going to the local level for the community.

**Public Comment:**

Vickie Mendoza, the Director of the Statewide Community Network of the United Advocates for Children and Families (UACF), asked if Senator Steinberg's proposal included peer support for parents and family members of children with mental health disabilities. UACF would like to see the inclusion of parents in peer support as part of the proposal. Ms. Van Maren agreed and stated that Senator Steinberg's office is open to ideas regarding the specifics.

Ms. Mendoza questioned how the governor's budget dealt with family services and the expansion going to the counties, and the flexibility of services in the counties. She stated that her concern over the level of services and agreed with Ms. Ryan that there needs to be some form of control. She emphasized the importance of implementing some kind of structure and including peer support. Chairman Van Horn suggested that Ms. Mendoza have a longer conversation with Ms. Ryan.

Joseph Robinson, the Associate Director of the California Association of Social Rehabilitation Agencies (CASRA), stated that CASRA supports Senator Steinberg's proposal. There is a shortage of alternatives to psychiatric institutionalization, and this is the opportunity to correct that. Too often, individuals are inappropriately placed in psychiatric hospitals because there is no alternative. He encouraged the Commission to support Senator Steinberg's proposal in concept and trusted that the details will be worked out.

**Action:** Commissioner Poaster made a motion, seconded by Vice Chairman Pating that:

*The MHSOAC enthusiastically supports Senate President Pro Tempore Darrell Steinberg's paper titled, "A Call for State Action: Invest in Mental Health Services for Community Wellness."*

- Motion carried, 9-0

**B. Adopt MHSOAC 2013 Financial Report (Action)**

Larry Poaster, Chairman of the Financial Oversight Committee, stated that, pursuant to Commission action last year, the framework was developed in which the Financial Oversight Committee would provide financial information related to the funding of a community mental health center. The Financial Oversight Committee will discuss the longer-range financial outlook in the next report.

Kevin Hoffman, Deputy Executive Director of MHSOAC, stated that the Financial Oversight Committee provides a financial report to the Commission twice a year, in January and May. The goal is to provide a simple, easy-to-understand report that shows funds coming in and going out, and to point out any possible policy implications.

Mr. Hoffman displayed a chart depicting the major funding sources in the mental health system: Proposition 63, federal financial participation (FFP), Realignment I and II, and the now defunct State General Fund. Funding of the overall system has grown since the enactment of MHSA and has stayed relatively stable. MHSA allocations to counties for the first nine months of 2012-2013 totaled \$1,154,000,000, which will exceed the amount projected by the governor.

Mr. Hoffman displayed a chart depicting MHSA funding revenue received at the state level. He agreed with Ms. Castañeda's statement in that it is fairly volatile, as shown by the fluctuations on this chart. He emphasized the importance of counties to have a prudent reserve for the lean years.

The financial report used to have a chart that showed component allocations, but, as these are now determined at the county level, the Committee created a new chart with numbers gleaned from the state controller's office. It shows the dollars that have gone out to the counties thus far.

Mr. Hoffman displayed a chart of the funds dedicated for housing and the amount assigned, the funds requested for housing projects, and the funds approved for housing projects, as well as how MHSA funds were leveraged. Some counties opted to put more of the community services and supports (CSS) money into housing, so the assigned amount is higher than the amount dedicated. The Committee will monitor the amount of leveraged funds, as they could be impacted by the elimination of the state's redevelopment agencies.

Mr. Hoffman displayed a chart depicting how MHSA administrative dollars are proportioned, listed by department. The Committee plans to ask some of these departments to give an update on what they are doing, their programs, and how they are spending the funds.

Mr. Hoffman displayed a series of annual Revenue and Expenditure Reports going back to FY 2004-05, tracking where the dollars were spent. He noted that the chairman of the Financial Oversight Committee requested that staff try to fill in the gaps in these annual reports.

#### **Public Comments**

No public comments were received.

**Action:** Commissioner Poaster made a motion, seconded by Commissioner Keith that:

*The Commission accepts the May 23, 2013, Financial Report as presented by the Mental Health Financial Oversight Committee.*

- Motion carried, 9-0

#### **4. FIRST READ: INTEGRATION POLICY PAPER: A VISION FOR TRANSFORMING THE MENTAL HEALTH SYSTEM THROUGH SERVICES INTEGRATION (POSSIBLE ACTION)**

David Pating, Past Chairman of the Services Committee, stated that he has adopted two transformation papers: A Vision for Transforming the Mental Health System through Evaluation, and A Vision for Transforming the Mental Health System through Consumer Involvement and Participation. Today, the Services Committee will present a first read on a third transformation paper: A Vision for Transforming the Mental Health System through Services Integration.

The policy paper is about integration of medical service delivery. Integration also means coordination, collaboration, and leveraging of resources and dollars, which results in improved outcomes and involvement with client participation and a whole-person approach. This paper will address this in two ways: with a “big ‘I,’” systemic integrations and collaboration with other state entities, and with a “small ‘i,’” the integrated service experience. He asked Commissioners to keep both perspectives in mind.

In 2007, the Service Committee wrote a paper on co-occurring disorders: clients with physical health, mental health, and substance abuse needs. These clients often end up incarcerated, on the street, in hospitals, or in foster care. Co-occurring disorders compound the medical and social issues. MHSA was designed as a safety net to meet those comorbid needs. This paper addresses the “small ‘i’” in order to try to address the necessary “big ‘I’” of discussion and collaboration to move systems forward.

At the September 2012 MHSOAC meeting, the Commission discussed what Commissioners would like to accomplish in the next several years. The top priority was to continue to pursue evaluation. The next two issues were broader and more vision oriented. Commissioner Pating stated that he hoped this paper would fill that need. The second vision was how the Commission can make sense of evaluation in a changing environment. The third vision was that the Commission needs to play a coordinating and collaborating role.

This paper will speak to that issue, to the needs of those with co-occurring disorders, and then look through this lens of transformation through integration to provide clarity on Commission activities moving forward.

Dee Lemonds, MHSOAC Staff, presented a PowerPoint. She stated that the report presented today would emphasize the importance of integrating physical health care with behavioral health services. The Commission has a vision of promoting integrated services as a best practice model for delivering effective and efficient services that result in positive life outcomes. As defined in MHSA regulations, “Integrated Service Experience means the client, and when appropriate, the client’s family, accesses a full range of services provided by multiple agencies, programs, and funding sources in a comprehensive and coordinated manner.”

There is an urgent need and opportunity to provide integrated services as a way to reduce costs and improve life outcomes for clients and families. The Commission recognizes this critical opportunity to focus on services integration and collaborate with other state and local entities to further promote integration between behavioral health and physical health care services. Successful recovery for individuals requires a focus on the whole person.

Vice Chairman Pating stated that he is proposing an amendment to the draft paper on page 2 for clarity as shown on slides 8 and 9. As envisioned, in a transformed mental health system that provides integrated behavioral and health care services:

1. Systems: Systemic integration strategies are broadly understood and documented at the state and local level,
2. Services: There are clear definitions of what constitutes efficient and effectively integrated programs and services,

3. Interventions: Integration services will identify and serve persons with mental health and SUDs throughout our health care and social service system.

Vice Chairman Pating stated that these three points work together from the bottom up. There is a need for a universal screening approach as in Item 3, so clients with mental health, substance abuse, and physical conditions can receive appropriate services; then, Item 2, link those that are identified to services and programs as best practices are identified in the state. Then, Item 1, at the Commission's level of being a system and a state entity, the Commission would work with the state and the counties to help them to resolve issues they have identified.

The next two transformation lenses will be overlaid on top of Items 1 through 3:

4. Evaluation: Local programs are able to report system-level outcomes related to integration, including developing evaluation capacity to determine if access to care and outcomes are improved for clients with co-occurring conditions.

5. Recovery itself is viewed from an integrated perspective, which addresses the ability of clients with co-occurring conditions to receive services that meet the needs of the whole person.

Vice Chairman Pating stated that, in an integrated system, effective coordination of services and interventions result in improved outcomes for whole persons and the whole system. He gave some recommendations as a sense of direction and a strategy for the Commission's future activities.

#### Recommendations

1. Integration at the federal level: MHSOAC would encourage that, during the current period of government realignment and restructuring, a high-level, permanent state entity be identified to work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to promote statewide integration of behavioral health care and physical health care services.

2. Integration at the state level: MHSOAC recommends that an appropriate state entity develop a unified mental health care delivery framework that guides and promotes optimally integrated service delivery for co-occurring behavioral health and medical disorders.

MHSOAC would welcome the opportunity to collaborate with the identified state entity and suggests an Integrated Services Workgroup, led by the identified state entity and including other state and county entities, to study and consider ways to:

- Define and identify various levels of integration and associated outcomes
- Collect and report data to measure integration, access to integrated services, and other outcomes arising from integration
- Overcome service fragmentation resulting from misaligned funding requirements arising from federal block grants, Medicare/Medicaid, and MHSA funding

3. Integration at the county level: MHSOAC encourages continued support of systemic integration activities and programs designed to promote integrated behavioral health and medical services, including those carried out by the Co-occurring Joint Action Council, the CiMH, and the Integrated Behavioral Health Project.

4. Integration at the local MHSA level: MHSOAC recommends that, as part of the local MHSA community program planning process, community stakeholders have an ongoing role in planning and development of strategies for programs that integrate behavioral and physical health care services. The Commission also suggests that, as DHCS develops and expands MHSA and Medi-Cal issue resolution processes, they address integrated services and involve stakeholders in the ongoing review of these processes.

5. Integration at the HCR level: MHSOAC recommends that statewide MHSA stakeholders involved in implementing MHSA programs seek opportunities to align MHSA services with program reforms mandated by the Mental Health Parity and Addiction Equity Act (2008) and the ACA (2010).

6. Integration at the public and private level: MHSOAC encourages the state to seek opportunities to enhance program and evaluation efforts through collaboration with private or public foundations serving un-served, underserved, or inappropriately served communities.

Vice Chairman Pating noted he added the words “program and” to Item 6: “...enhance program and evaluation efforts...”

### Conclusion

MHSA envisions a transformed mental health system. The Commission’s vision is that:

- Individuals receive comprehensively integrated services delivered in a culturally-competent system of care with identified strategies for integrated service access.
- Mental health services are delivered in collaboration with non-mental health partners.
- Peers and families foster client- and family-centered wellness and recovery.
- Individuals have an integrated service experience including services received through MHSA’s component programs.

This paper is intended to guide Commission activities to promote greater system-wide mental health competency. Toward this goal, the Commission reasserts:

- Services for co-occurring conditions at all levels must continue to be culturally-competent, gender-responsive, and trauma-informed, as well as focus on special populations including older adults, transition-age youth (TAY), and individuals either currently in or recently released from the criminal justice system.
- The Commission also intends that the expertise of clients, parents, family, and caregivers with lived experience of co-occurring disorders that include physical health care conditions significantly inform the planning, design, implementation, and evaluation of integrated services and programs.

### **Commissioner Questions:**

Commissioner Carrion stated that the need to ensure consideration of the Health Insurance Portability and Accountability Act (HIPAA) procedures and different groups that must use different systems not being able to share data. He recommended studying the United States Department of Veterans Affairs (VA) system.

Executive Director Gauger stated that this paper gives staff a better understanding of the Commission’s vision for integration and future direction. It is helpful for staff to have a common set of principles. Staff

can then promote these principles and include them in conversations. The Commission also has, by law, the expectation that it communicate with the Legislature and with the administration on emerging ideas and concepts. Staff would utilize this paper to facilitate those conversations.

Commissioner Gordon stated that integration can also occur across time. One of the problems in working with schools is that many people do not understand that children can experience mental health problems. It is very hard to push the notion of early identification and early intervention. He suggested adding the words “as early as possible” to Slide 16, Item 1, “...integrated services delivered as early as possible in a culturally-competent system...”

Vice Chairman Pating agreed and noted that the Commission uses the phrase “across the lifespan.” He stated that he will work with Deborah Lee to make sure that this aspect of prevention is included.

Commissioner Mallel suggested adding that therapeutic intervention has some parent choice, if the parents can have a say in what they think would be best for their child. Vice Chairman Pating asked if it was adequate to frame it as “family involved in the decision making” or “family-centered approach.” Commissioner Mallel agreed.

Commissioner Correa agreed to some additional language in that area, and stated that the whole family should be part of the solution.

Commissioner Keith emphasized the need for evidence-based effective services, because there are many services for children with various kinds of developmental disorders with little evidence that they are effective. He recommended that the Commission promote evidence-based treatments.

Commissioner Carrion added that the family is the first line for children; since children are considered unable to make decisions for themselves, parents have to be part of that decision-making process.

Commissioner Keith added that parents are typically very involved in the follow-through of the recommended treatments. They need a voice in the selection of treatment.

Vice Chairman Pating stated that he will speak with Commissioners Carrion and Keith later about these issues.

**Public Comment:**

Charles Hughes, of MHSA Our Way, stated that there are many good points in this paper. He encouraged the Commission to use the term “best outcomes” over “best practice,” because best practice means the most popular practice. He stated that it is well-known that West African Shamans have better outcomes in Schizophrenia than North American psychiatrists. He suggested those two be integrated where clinics have a West African Shaman.

Sandra Marley, a consumer and advocate, stated that this has been a very productive meeting. This past year has been very different, but now the focus is back on public relations and transparency. She suggested adding baby-boomers to the special population to focus on. She referenced a report that states suicide in baby-boomers has increased by 30%. There are a lot of troubling things in that group.

David Czarnecki, the Advocacy Coordinator of the National Alliance on Mental Illness (NAMI), California, stated that this initiative is very important and long overdue. As the largest California institute that

represents family and consumers, NAMI approaches with caution anything that says “family when appropriate” when that phrase is undefined. He stated that he supports the Services Committee’s intent to work with the Client and Family Committee to define what a whole person is, and asked if there is a role for families and consumers in the integrated services workgroup.

Vice Chairman Pating stated that the workgroup is a future concept. The Commission will propose this notion to the state agency that comes out of the newly-formed DHCS.

**Commissioner Discussion:**

Commissioner Poaster stated that the Commission’s policy is that there be two reads on policy issues unless there is a significant timing issue related to it. He stated that he was skeptical due to the paper’s lack of preciseness. While he understood the need for a broad vision, his experience is that integration has led to the diminution of mental health and drug and alcohol services. He stated that his skepticism of using a term, when the very first goal is to define what that term means.

Chairman Van Horn stated that staff will integrate the amendments discussed today into the paper and have a second read in the July meeting.

**5. CONSIDER RECOMMENDATION TO AUTHORIZE THE EXECUTIVE DIRECTOR TO EXECUTE CONTRACTS NOT TO EXCEED \$464,000 FOR STRENGTHENING DATA COLLECTION SYSTEMS and DATA QUALITY IMPROVEMENTS (ACTION)**

Renay Bradley, Ph.D., the Director of Research and Evaluation of MHSOAC, stated that the Commission has adopted an evaluation of MHSA and broader public community-based mental health system as a priority. This effort is continuing that approach.

In September 2012, MHSOAC approved the Evaluation Committee’s recommendations on how to use the Commission’s current FY funds, including what was then referred to Proposal Z, which focused on strengthening the data collection and reporting systems within the CSS component.

Through this contract, the Evaluation Committee would like to put further support into the Client and Service Information (CSI) system, which collects client-level data, as well as the Data Collection and Reporting (DCR) system, which focuses on full service partnerships (FSPs). These data systems are fundamental to the Commission’s evaluation role, and several activities outlined in the Evaluation Master Plan are dependent upon receipt of that data.

Through the scope of work with these contracts for CSI, the Evaluation Committee is proposing to identify problems with county collection and reporting systems, and identify and share best practices with counties via webinar and a statewide report. Those steps are in the process of being completed or have already been completed for the DCR system. The contractors have identified necessary IT fixes within DHCS.

Regarding the proposed contractor qualifications, the Evaluation Committee is proposing to contract with Mental Health Data Alliance, a newly-formed small business owned by Kate Cordell.

**Commissioner Questions and Discussion:**

Commissioner Poaster stated that his understanding that this will be the last time the Commission will be devoting MHSA funds for data cleaning. Dr. Bradley stated that no more funds will be encumbered

for this upcoming FY. However, annually for four years, the Evaluation Master Plan proposes putting \$500,000 toward this effort.

Commissioner Poaster asked if the Commission can expect to continue to use the evaluation money for the purposes of cleaning the data systems. Dr. Bradley stated that this is what the Master Plan proposes at this time.

Executive Director Gauger added that it is the end of the Commission's intent to use the Commission's projected surplus for data cleaning. Part of why the administration ultimately supported implementation of the Master Plan was that it included a piece that was dedicated to continuing to improve the data system.

Commissioner Poaster stated that his concern that this Commission is cleaning up the entire DHCS data system. Chairman Van Horn agreed, but stated that the Commission cannot evaluate without data.

Executive Director Gauger added that the Legislature has only approved the first year of the Commission's implementation plan. The Commission will have to seek additional funds next year, and something else could be proposed at that time.

**Action:** Commissioner Carrion made a motion, seconded by Vice Chairman Pating that:

*The Commission authorizes the Executive Director to execute contracts for not more than \$464,000 to complete the Scope of Work and Deliverables focused on strengthening of data collection and reporting system as presented.*

- Motion carried, 9-0

## **6. REPORT FROM MARCH 14, 2013, MHSOAC COMMUNITY FORUM HELD IN THE COMMUNITY OF SAN BERNADINO**

Raja Mitri, a member of the Community Forum Workgroup, thanked staff, Commissioner Wooton, and Commissioner Nelson for their support and assistance with the presentation. He stated that he and Ruth Tiscareno, a member of the Community Forum Workgroup, have participated in the Community Forum Workgroup from its beginning and have watched the forums evolve into enthusiastic community events attended by hundreds of stakeholders.

Mr. Mitri reviewed the five goals of MHSA Community Forums:

- Provide opportunities for the Commission to hear firsthand from clients, family members, and other stakeholders
- Gather information and stories about experience and the impact of MHSA
- Expand public awareness and education about Proposition 63, MHSA, and the Commission
- Expand the visibility of the Commission by holding community forums throughout California
- Provide an annual report to the Commission

Mr. Mitri stated that many participants have made positive comments about the presence of Commissioners in the forums. The next Community Forum will be in Rohnert Park on June 13, 2013, from 3:00 p.m. to 6:30 p.m.

In 2011, the format for MHSA forums was changed so that participants could offer their input in separate discussion groups, which created a safe space to share their experiences. He reported that over 1,270 individuals have participated in the last seven forums.

Ms. Tiscareno stated that almost 40% of the participants who turned in their questionnaires indicated that, before the forum, they had not heard of Proposition 63 or MHSA, and over 40% indicated they were not aware of programs and services funded with MHSA dollars in their communities.

Based on feedback at MHSA forums, there were nine services that have changed or been expanded since implementation of MHSA that participants identified as the most effective: peer support services, family education, innovation programs, services in schools, prevention and early intervention (PEI) programs, cultural sensitivity, access for un-served and underserved, services across the life span, and services that promote self-sufficiency.

Mr. Mitri stated that participants in MHSA forums have identified five most significant service challenges: access to services, respite services, supported employment and education for improved life outcomes, coordination and navigation between public and private health care services, and community education.

MHSA Community Forums have generated interest and enthusiasm and participation has increased over time. They perform a valuable service of educating and informing the community about MHSA and the Commission. They provide an opportunity for the Commission to hear the experience and perspective of community members, which is a significant factor in the Commission's decisions, recommendations, and future policy direction.

#### **Commissioner Questions and Discussion:**

Vice Chairman Pating asked for a comparison of findings between MHSA Community Forums and the community-based participatory research and how to reconcile the two kinds of data the Commission is receiving.

Mr. Mitri stated that the participation evaluation study was limited in looking at the data of cultural groups. Disaggregation of the data to capture the cultural heritage within the broader categories, such as Latino and Pacific Islander, is crucial to sensing how services are culturally congruent to meet the needs of those communities. Over time, there has been an increase in attendance of MHSA forums from cultural groups who express a desire for more information, not only about MHSA, but about mental health in general, and to have materials provided for them in their language. Mr. Mitri stated that his hope that the Commission will continue to study racial and ethnic backgrounds in order to capture the cultural heritage data of the different communities.

#### **7. GENERAL PUBLIC COMMENT**

Mr. Hughes stated that he has been to a number of wellness centers in Shasta County and feels they have an "us versus them" culture. People find it depressing, because they feel they cannot speak freely. Mr. Hughes stated that the staff hold a different view and are not recovery informed. There are ten computers in the center and none of them work; but, if they did, he feels the staff puts too many

restrictions on them. He stated that, in recovery, consumers need the counsel of peers so that they can talk freely among themselves.

Chairman Van Horn agreed that some wellness centers are certainly better than others. The move towards a recovery model varies around the state. The Commission is working on this issue.

#### **8. PRESENTATION OF THE (1) EVALUATION BRIEF ON OUTREACH AND ENGAGEMENT AND (2) VARIABLES ASSOCIATED WITH FULL SERVICE PARTNERSHIP EXPENDITURES AND COST OFFSETS**

Elizabeth Harris, Ph.D., of Trylon Associates, stated that she presented the statewide findings related to FSP costs and cost offsets to the Commission in November 2012, and today she presents the rationals and context for those prior findings.

The University of California, Los Angeles (UCLA) team was charged with identifying the statewide and county annual and per-day expenditure of providing FSP services by age group, and the cost savings realized through FSP services. There were fifty counties in the analysis. UCLA relied on existing data, but the revenue and expenditure data alone was insufficient to answer the question of cost per age group, as it only documents expenditures by program. UCLA augmented that data by launching a web survey to counties and examining state FYs 2008-09 and 2009-10. Counties were interested in focusing on FYs with robust DCR data, because that was where the outcome data was collected from.

UCLA studied FSP services using existing data; looked at plans, annual updates, and county proposals; and reported on services as planned, not services as implemented. The plans for services and the age groups served varied across the counties. The charts in the report reflect only what counties documented in the plans, but counties may provide services that were undocumented. The “Other Supports” category includes services such as providing food to families or transportation. UCLA looked at the “Peer Involvement” category from a broader perspective, such as whether peers were on staff and included in the team. Over 90% of counties had peers involved in some capacity. Dr. Harris encouraged Commissioners to look at the “Evidence-Based Practices” category in the full report. Across the counties, there were many different models and a wide range of evidence-based practices being implemented.

The county range of the FSP number served varies widely across the counties, from 5 to 3,100 served in one year, depending on the age group served and the size of the county. Small counties were pooled in the full report. The annualized FSP expenditures per client also vary widely. For each age group other than adults in 2008-09, the highs are higher, as compared to 2009-10 where they level off more. Dr. Harris theorized that this speaks to programs maturing, having worked through the rough areas in the beginning and then experiencing increasing efficiency.

UCLA analyzed the factors related to cost. The model was severely limited by the inability to look at services as implemented or the amount of time services were received. Of the nine factors identified, the poverty level and the percent of insured individuals impacts the outcomes, as has been shown in many national studies.

UCLA looked at county contextual considerations for FSP expenditures and found that counties that had higher percentages of insured children correlated with higher average daily expenditures for children, youth, and families (CYF), and lower percentages of CYF living in poverty correlated with higher

expenditures for CYF. Also, for race and ethnicity, they found that counties with higher percentages of Caucasian FSPs served had higher average expenditures for CYF and TAY.

UCLA only looked at the FSP new enrollees to analyze the cost offsets. There was a wide range of numbers served across the counties. Some counties spent more on their clients than they were able to realize in offsets; yet, overall, the big picture statewide was still very impressive.

UCLA looked at county contextual considerations for FSP offsets and found that, for CYF, they were able to look strictly at the number of service options. Offering more service options did not necessarily result in greater cost offsets, but, for CYF, the offsets may not show up for a year or two because they are younger. There are a number of factors that UCLA was not able to look at that have been shown through research to be important to outcomes, such as clinical diagnosis and encounter data, which are not part of the DCR. UCLA did not find anything for gender, race, and ethnicity due to the data limitation.

Many counties are implementing a number of evidence-based practices, but UCLA did not have access to data regarding fidelity in implementation, which impacts outcomes. Dr. Harris suggested that the Commission consider studying this issue, and recommended asking Todd Gilmer, Ph.D., to speak to the Commission on his findings in this area.

Another area UCLA looked at was outreach and engagement. They identified outreach and engagement expenditures, studied if the populations were reached, and examined the settings and staffing. UCLA had access to the 2009-10 Revenue and Expenditure Report and the 2011-12 Annual Update. Almost all counties are implementing some form of outreach and engagement. Counties documented reaching 89,533 individuals. The settings where counties conducted the outreach and engagement varied widely. Counties reported a staffing mix of paraprofessionals and professionals.

The average amount expended on outreach and engagement was \$1.2 million in FY 2009-10, ranging from \$8,000 to \$32 million. UCLA was able to break the percentages down by age group through the survey for the cost offset study, which included questions about outreach and engagement.

#### **Commissioner Questions and Discussion:**

Commissioner Carrion stated that his understanding that, independent of county size, counties vary widely in terms of the services that are delivered and how they handle fiscal administration. He asked how the Commission can make general recommendations for such a heterogeneous group of counties.

Dr. Harris stated that there needs to be more precise data collected about county-level implementation.

#### **9. PANEL PRESENTATION ON BEST PRACTICES FOR REDUCING THE NEED FOR INVOLUNTARY TREATMENT**

Chairman Van Horn stated that this panel is in relation to topics in discussion today: Senator Steinberg's initiative and Senator Steinberg's SB 364, and the overhaul of Section 5150, bringing more clarity and coherence statewide. He asked the panel if what they found really works in reducing involuntary treatment.

### Don Kingdon

Don Kingdon, the Deputy Director of CMHDA, stated that this issue is very important for counties. Ever since what many consider a landmark civil rights legislation, the Lanterman-Petris-Short (LPS) Act, which gave due process rights to individuals who were being detained for mental illness, CMHDA has followed this closely, and felt it was appropriate this year to adopt a set of principles related to involuntary treatment. He highlighted a few of those principles:

- No matter the legal status of the individual, all treatments' primary goal should be to promote resiliency, wellness, and recovery.
- It is a community issue, not just a county mental health issue, and CMHDA needs to encourage the use of all existing community resources and the development of new ones.
- There is an important role for law enforcement and for hospital emergency departments in assessing and determining whether or not conditions require mental health treatment.
- It is important, no matter the legal status of the individual, to encourage self-determination in terms of treatment goals. It is important that the consumer feel engaged; ultimate recovery requires the support of the consumer.
- All of these principles when applied should increase the effectiveness of treatment, regardless of the legal status of the individual. The focus, from the county mental health perspective, is providing access to treatment while the court process is occurring.

### Mike Kennedy

Mike Kennedy, the Director of Sonoma County Behavioral Health, stated that Sonoma County is a mid-sized county with 500,000 individuals. It had two inpatient psychiatric hospitals in Santa Rosa in 2007, but none were left by 2009. Sonoma County had to find alternatives and work on a system to help deal with crisis, whether voluntary or involuntary. Through MHSA, Sonoma County has three tiers of services:

- A group of crisis outreach programs and crisis intervention training (CIT) with law enforcement in 2005 that has trained over 350 officers
- A mobile support team that meets law enforcement in the field on 5150 calls seven days a week from 2 p.m. to midnight
- An outreach program that works specifically with homeless shelters and alcohol and other drug services (AODs) providers

There are people in the field who are available for crisis intervention.

One of Sonoma County's most successful programs through PEI is a mobile team called the Crisis Assessment Prevention Education (CAPE) team. That team is responsible for the community college and nine high schools, and, in the fall, will be adding Sonoma State University. CAPE sits on the crisis team at the health center to exchange information and link students who are in crisis directly to the Psychiatric Emergency Services (PES). The CAPE team is able to stabilize kids and keep them in school because they are intervening early. All Sonoma County outreach staff is trained to teach "Question, Persuade, and Refer" (QPR), a short training that can be given to parents, students, and teachers, that teaches what the signs of depression, suicide, and mental illness are, the questions to ask, how to make referrals, and how to link back to Sonoma County services.

The PES program has a crisis stabilization unit, where law enforcement drops off any 5150s or anyone who needs to be assessed. The PES is located across the street from Sutter Hospital and does all medical clearances there. Sutter has a contract with Sonoma County to do the consultations on psychiatric issues in their Emergency room (ER). Memorial Hospital is looking to contract with Sonoma County also. These links to the ERs provides opportunities to intervene early with individuals.

Sonoma County added a crisis residential program five years ago that is run by Progress Foundation out of San Francisco. It is a place where people can be moved once they stabilize, if they do not have to be hospitalized. Even if hospitalization is necessary, once they are doing better, they can be brought back to the crisis stabilization unit. This step down reduces stays in hospitals or avoids them altogether. Sonoma County also has a thirty-bed detox program where PES and detox work together and share resources.

Next month, a new, freestanding psychiatric hospital is opening in Santa Rosa called Aurora Behavioral Healthcare, which will have ninety-five psychiatric beds in five units in Sonoma County. In the old model, where the PES was attached to an inpatient unit and it was necessary to keep the beds filled, many times people were pulled from the PES when they did not need it. The difference now is that it will only be used when necessary and people will be moved out quickly because there are alternatives. The model where PES is separate from running the psychiatric beds is a better model, because the goal is to keep people out and to get them back to their homes as quickly as possible.

Having a physical PES or crisis stabilization is important and is a way to partner with the ERs so that there are more appropriate treatment models. Some of the minor changes the Commission was discussing with Senator Steinberg's bill may make it easier for some counties to have a crisis stabilization or PES site. Although it is expensive, it is an important piece to stabilize people. Many times people can be stabilized within twenty-three hours and return to their homes.

#### **Commissioner Questions:**

Chairman Van Horn asked if the new twelve-bed facility is Medi-Cal reimbursable. Mr. Kennedy stated that it is.

Commissioner Carrion asked if the PES could do the assessments that the ER does in terms of toxicology and blood work. Mr. Kennedy stated that it is necessary to be located near an ER, for both PES and detox, because there are medical clearances that have to be done. The relationship is important, and it is also important for hospitals and ERs to be involved with mental health services.

Commissioner Lowenthal asked if Sonoma County has curriculum for mental health education in schools. Mr. Kennedy stated that QPR is an evidenced-based curriculum and is a powerful tool.

Commissioner Lowenthal asked if Mr. Kennedy has had conversations with the Department of Education or just in the local school districts. Mr. Kennedy stated that the local school districts and the community college are important proponents of it.

Commissioner Lowenthal stated that she asked that question because she had a bill in the Legislature to develop curriculum on mental health training that was scored as too expensive to do; she could not get support from the Department of Education.

## Lisa Smusz

Lisa Smusz, the Executive Director of Peers Envisioning and Engaging in Recovery Services (PEERS), stated that PEERS is a consumer-run organization in Alameda County near Oakland, is a solutions-oriented organization that believes recovery is possible for everyone, and helps people move past crisis and into recovery. PEERS collaborates peer-directed activities and interventions with clinical and traditional mental health services, and backs up their interventions with research and good evidence-based outcomes.

Ms. Smusz shared one of the innovative programs PEERS has done that reduces the need for involuntary treatment: Mentors on Discharge. The program was started about two years ago. There are a large number of consumers in Alameda County that are frequent users of ERs, are often re-hospitalized, and are 5150ed on numerous occasions. She stated that it seems to be a certain set of consumers that are repeatedly re-hospitalized and subject to involuntary treatment.

PEERS wanted to find out if there was something that could be done that was peer directed, that could partner with the traditional mental health facility, and was cost-effective, to help stop the cycle of re-hospitalization and provide cost-effective, community-based voluntary treatments that could help people move towards recovery. PEERS partnered with the John George Psychiatric Pavilion, the local facility where people are sent for involuntary treatment, and put together a year-and-a-half long innovations project to study the impact of a seemingly simple intervention.

Program Design - PEERS is a proponent of studying and cultivating the successes and sharing that knowledge in the community. They identified individuals with mental health issues who had been involuntarily committed in the past, had gone on to recover, and were living successfully in the community, and trained them in peer counseling and mentoring techniques.

PEERS also identified individuals who had been repeatedly taken to a treatment facility as a result of 5150, and offered them the opportunity to meet with a mentor. Those who volunteered to participate met with a mentor while still in the facility. They continued meeting with them after they were released for about an hour at least once per week, face to face, to connect and talk, and had at least one phone call per week.

PEERS followed these connections for a year and a half. All who participated were studied, as well as all the hospitalizations they had had previous to the program, how frequently they were hospitalized, and the duration of the stays. PEERS then measured after the intervention, for an equal amount of time, how often they were hospitalized and, if they were hospitalized, the duration of the stay.

Visiting hours are extremely limited in locked facilities. The visiting hours had to be extended to allow the mentors to come into the hospital to make those connections, because it was necessary that these be optional visiting experiences, not just another clinical-type appointment. John George Psychiatric Pavilion worked with PEERS to broadly extend the visiting hours. If they did that for the mentees in the PEERS program, they had to do it for everyone in order to make it equitable. That ended up having a huge, unintentional consequence to be shared later in this presentation.

Final Results - Ms. Smusz reported the following results at the end of the grant period:

- The number of participants in the Mentors on Discharge program was 60.
- The number of hospitalizations in the twelve months prior to participation was 173 versus 48 in the twelve months after participation.
- The average number of days between hospitalizations before the intervention was 62 days versus 159 days after intervention.
- The percentage reduction of hospitalizations for the participant group was 72.3%.

Ms. Smusz stated that this is a wonderful, inexpensive, very effective program with unexpected, amazing results.

The short-term innovations grant was \$238,000 for administrative work, to pay and reimburse the mentors and researchers. In that program, 125 hospital admissions were saved or avoided. The average cost of hospitalization at John George is \$8,500 per admission. The total gross systems savings was \$1,062,500; without the grant dollars of \$238,000, the return on investment was \$824,500. For every dollar spent on the program, PEERS saved roughly three dollars. This does not include the cost for the 5150s for law enforcement, or the human cost to the families or to the people who had gone through this traumatic experience again and again. The program was a huge success, both in terms of the social return and the fiscal return on investment.

PEERS' goal is to share and replicate these results. It is a very inexpensive program and is designed to be easily replicated throughout the counties of California. Because it is the consumers from a community who are trained to be the mentors, it is culturally responsive for whatever community it is launched in. The mentors are the representatives of the community and of the people that they are trying to connect with in the hospital. This is one of the reasons it was extremely effective.

Possible Future Research - PEERS would like the opportunity to research an unintended result of the program: the impact on seclusion and restraints. She mentioned previously that the visiting hours had to be broadly expanded in order for the mentors and the mentees to connect in the hospital. This unexpectedly resulted in a dramatic drop in the rates of seclusion and restraints that had to be used in the facility during the period of the study. Not only did it drop dramatically for the participants, but for all of the patients. She theorized this was due to the increase in visiting hours: more family and supporters came in for more hours. Having someone there to connect with and support patients reduced agitation and crisis.

PEERS would like to study the impact on the mentors' sense of empowerment and utilization of services. There were two people in this relationship; PEERS only studied the impact on the mentee, not the impact on the mentor, the person who was a successful consumer living in the community, received this training, and then helped another person and participated in their recovery. PEERS would like the opportunity to study the mentors to see their sense of empowerment and healing and how that impacted their utilization of services.

PEERS would like to examine the role of mentoring for those at risk of 5150 hospitalizations as a preventative measure.

PEERS is also seeking funding to replicate this program across other counties and then to see how that manifests in nonurban areas to compare the results.

**Commissioner Questions:**

Commissioner Carrion asked if there was a group that did not have mentors. Ms. Smusz stated that there were those in the hospital that refused to participate in the program, but they were not set up intentionally as the control group.

Commissioner Carrion stated that there are two things operating: the increase in visiting hours and the mentors. He asked if PEERS tracked what the mentors were doing and saying. Ms. Smusz stated that they tracked the content, the length, and the setting of the conversations. They found that the content of the conversations was not statistically significant as a determinant of the outcome of the patient, but it was the relationship that was the therapeutic agent.

Commissioner Carrion suggested, as the sample size increases, studying whether the content does become important and play a role within the variable of the relationship.

Commissioner Keith asked what percentage accepted a mentor. He also asked if PEERS did an analysis of those that did accept a mentor to study if their characteristics may add to this therapeutic effect. Ms. Smusz stated that they collected data on the percentages of those who refused the program versus those who accepted, and collected demographic data on those that did accept. PEERS did not study them within the scope of this research study, but focused on the outcomes on the mentees.

Commissioner Lowenthal asked about the ethnic breakdown. Ms. Smusz stated that she will send the Commission the full report and slides for their review for more in-depth analysis. It was an ethnically diverse group. The Asian Pacific Islander (API) was a low percentage. It was a nice, well-balanced group, as were the mentors themselves.

Commissioner Brown asked how PEERS vetted the mentors. Ms. Smusz stated that PEERS identified potential mentors from individuals they work with on a regular basis in the PEERS program Wellness Recovery Action Planning (WRAP). There was a large cohort of consumers trained as certified WRAP facilitators, and many of the mentors were pulled from that group because they already had some experience with facilitation techniques and empowering others and also had a history of living successfully in their recovery for some time.

In terms of quality assurance, PEERS trained the mentors in a week-long protocol, essentially a peer-counseling technique, and they attended monthly continuing education meetings. A coordinator of the program was available by phone and email on a regular basis to provide further support. Also, the mentees completed a customer satisfaction survey.

Joseph Robinson

Joseph Robinson, the Associate Director of the California Association of Social Rehabilitation Agencies (CASRA), stated that he had the privilege earlier this week of hearing Senator Steinberg introduce an MHSa project film entitled, "Each Mind Matters," where Senator Steinberg stated that his original idea and intent was that, in the beginning, 25% of MHSa funds would be for PEI and 75% would be for direct service, in the hope that this would shift.

Mr. Robinson stated that what he heard today is a shifting, putting more money, more attention, and more services on the front end. Involuntary services and psychiatric hospitalization are the most expensive services, and they need to be part of the continuum of services, but there are many other services that can help prevent and provide better clinical outcomes that are not as costly.

The 1115B waiver that went into the Centers for Medicare and Medicaid Services (CMS) from DHCS originally stated that “there is a shortage of psychiatric beds in the state.” CASRA was successful in negotiating with them, and the change became “there is a shortage of options for individuals in acute psychiatric crisis.” The more mobile crisis teams, crisis residential programs, and peer mentoring programs there are, the fewer people go into psychiatric hospitalization.

Another key is that their stay is shorter. Oftentimes, individuals go into psychiatric hospitalization because there is not an alternative, but they also stay longer because there is not a place for them to transition to. This is the opportunity to look at what alternatives could be available to shorten that time. Senator Steinberg’s mental health package is a tangible way of reducing hospitalizations and providing options.

#### **Commissioner Questions and Discussion:**

Commissioner Lowenthal asked to be reminded about the Hospital Association bill. Mr. Robinson stated that it was a Hospital Association bill originally, but it no longer is and there is no connection with Senator Steinberg’s current SB 364.

Commissioner Lowenthal stated that her concern that the hospitals have to keep people much longer because there is no place to go in the community. She offered to look into that issue with members of the panel.

Mr. Kingdon stated that the bill, as it is currently constructed, does address those kinds of issues. One of the problems is that there are not many options for certification of facilities, because the regulation contained old staffing requirements. The bill addresses that and creates an alternative to designated facilities where professionals, designated by the county, can do intervention in the community, including in ERs and hospitals.

Vice Chairman Pating requested that staff create a one-page summary of things MHSa is doing to reduce hospitalizations, including Alameda and Sonoma Counties’ programs, before Senator Steinberg’s press conference. He also asked staff to add the category “crisis-related alternatives” to the clearinghouse. He stated that, in regards to peer involvement, a system of certification for peers is essential to enable them to gain employment at different hospitals to avoid duplication and inefficiency. He asked Ms. Van Maren to request that Senator Steinberg look into this.

Chairman Van Horn stated that there has been an effort, over the years, with CASRA, to engage in a certification program for psychosocial rehabilitation practitioners. He plans to contact Betty Dahlquist, the Executive Director of CASRA, next week. It is important to ensure that whatever happens next has a career track built into it.

Vice Chairman Pating recommended a basic-level certification program on how to work within a health system, such as an eight-hour class teaching what HIPAA and a 5150 are and who to call.

Ms. Smusz stated that she will share the materials on peer certification PEERS developed from the Working Well Together conference last week.

Commissioner Lowenthal stated that her concern about who would bear the costs of certification. The cost to the state could potentially be enormous; it would not go anywhere if it was legislatively introduced, but there may be other ways of doing it.

Vice Chairman Pating asked if there are national peer certification standards. It is a matter of setting some standards, but the training and certification could be done by a national agency at the individual's expense.

Chairman Van Horn stated that there have been several pieces of national dialogue on this. None of it is complete yet, but it is moving ahead.

Ms. Smusz stated that there are thirty-five states with a peer specialist certification. CiMH, NAMI, UACF, and PEERS have been looking at those models and how other states have done this as a part of the Working Well Together project, as well as what the core competencies would look like. She stated that she will share those materials with the Commission.

Commissioner Poaster asked how the Commission can help in this effort. Ms. Smusz stated that PEERS has been putting quite a bit of effort into this and she welcomed an opportunity to share that information with the Commission and to have a discussion about how to partner together.

Commissioner Poaster recommended meeting with Executive Director Gauger and seeing how the Commission can be helpful in this effort.

**Public Comment:**

Delphine Brody, the Public Policy Director for the California Network of Mental Health Clients (CNMHC), applauded the work of the panelists to address this critical issue of reducing the frequency of involuntary hospitalizations. She stated that she is pleased to hear about the proposed expansion of crisis residential facilities through Senator Steinberg's proposal, the increased access being made available in Sonoma County, and the PEERS program.

Ms. Brody stated that her concerned that the ninety-five-beds in the new Aurora facility in Sonoma County will call out to be filled even with the different arrangement that exists where PES is not directly in charge of the unit. She stated that any increase in the number of involuntary beds is a step backwards in this effort. She requested further explanation on crisis stabilization and whether the crisis stabilization unit is a locked facility and a barrier to people that may not be necessary. She stated that there is not enough growth in peer-run crisis residential alternatives or enough MHSA funding. She added QPR has been problematic in terms of empowerment.

Steve Leoni, a consumer and advocate, stated that he was grateful to hear of the PEERS program and that they have listened to consumers. He stated that he volunteered at a crisis residential facility for twenty-five years. He stated that people do not stick with anything that long unless they get something back. He stated that he may be partly able to answer the question what happens to the people in the mentor position.

Mr. Leoni stated that helping people at the crisis residential facility gave him a reason to be alive in his worst times; it was something to focus on and a wonderful satisfaction, because it was a place of healing and where people got better. It was being part of a healing community that made it work. He only stopped volunteering there when he became involved in advocacy.

Mr. Leoni stated that doing outreach and connecting with people before they reach a full crisis avoids the crisis entirely. He recommended the outreach and engagement be peer-driven. This idea is lost because it is not in statute or regulations specifically. By reaching out, connecting, and working with people before hospitalization, participation in the Mentors on Discharge program will increase.

## **10. CALIFORNIA REDUCING DISPARITIES PROJECT UPDATE**

Kathleen Billingsley, the Chief Deputy Director of Program and Policy of the California Department of Public Health (CDPH), provided an update on CDPH and the Office of Health Equity (OHE), focusing on the development and upcoming release of the strategic plan.

CDPH and the OHE have gone through a stakeholder interview process to identify the best candidate for the governor-appointed position of deputy director of the OHE, and are close to selecting a candidate. Also, the first meeting of the newly-assembled, twenty-six-member OHE Advisory Committee will be at the end of August.

They are in the process of finalizing an interagency agreement between DHCS and CDPH, which will allow them to complete many of the responsibilities of the OHE and DHCS, such as sharing data, having the medical director of DHCS participate on the OHE Advisory Committee, working on cultural competency plans at the county level, and working on the OHE strategic plan.

### The California Reducing Disparities Project (CRDP) Strategic Plan

Ms. Billingsley stated that CDPH is getting close to publishing the strategic plan on the website. Once it is published, there will be a thirty-day comment period, followed by a sixty-day period, and then finalization of the strategic plan. There are twenty-four strategic plans within this plan. Ms. Billingsley shared five of them:

- To locate mental health services with other community based agencies
- To engage in a culturally and linguistically competent workforce
- To support community involvement and engagement
- To develop culturally-specific mental health practice models
- To replicate community-based practices that have proven to be effective

Ms. Billingsley apologized that the meeting today did not coincide with the release of the strategic plan and recognized that it must be frustrating and disappointing to the Commission. It has taken longer than CDPH would have liked to release the strategic plan.

### **Commissioner Questions and Discussion:**

Chairman Van Horn stated that he expected to see the strategic plan today, and Commissioner Poaster stated that he feels frustrated by this report. Most strategic plans are for the purpose of someone

implementing something. Commissioner Poaster asked who the customer of the strategic plan is and who will be implementing it.

Ms. Billingsley stated that the customers are the members of the community, including the Commission, who are waiting for this strategic plan to be outlined. The implementation takes place through the Request for Proposal (RFP) process, which is overseen by CDPH. Once the RFP process is complete, the money will begin to move out into the community to tackle the objectives of the CRDP strategic plan.

Commissioner Poaster stated that this is an approximately \$4.5 million strategic plan that has been in the process of being implemented for three years now. It is frustrating that there are \$40 million ready to be converted into services to the community that are gridlocked waiting for this plan.

Commissioner Poaster stated that he has been on the Commission for some time and feels some ownership in the creating of the statewide program. He was disappointed upon hearing that the Mental Health Services Act Oversight and Accountability Commission would be allowed to view the strategic plan along with the rest of the universe on the website for thirty days, and were not given the courtesy of an advanced look. He stated that he does not know why this cannot be a more transparent process.

Ms. Billingsley stated that the Commission will receive a copy prior to the time it is posted, but did not know a specific timeframe.

Commissioner Poaster stated that his understanding that the strategic plan was completed in November and was sent up to Agency at that time. Ms. Billingsley stated that it has been slightly modified since then, but was not definitively finished in November.

Chairman Van Horn agreed with Commissioner Poaster in that the Commission has been involved in this from the beginning of PEI, and is feeling disrespected by the administration.

Ms. Billingsley stated that it is her personal commitment, as part of the administration, to ensure that the strategic plan is a fine product and that it is released as quickly as possible. The Commission is highly regarded in CDPH, which has great respect for what the Commission does, the directions it takes, and the directions it gives CDPH. She apologized that this is leaving the Commission with what seems a hollow commitment, instead of being able to provide a copy of the plan.

Commissioner Poaster asked how soon the \$40 million can begin being used once the strategic plan is out. He stated that his concern that the money is sitting there when it could be serving a useful purpose in the communities. Ms. Billingsley stated that she does not have an exact timeline, but can send that information to the Commission. The RFP would be completed in the fall, and then the money can begin to roll out after that.

Vice Chairman Pating asked if evaluation is a separate recommendation in the strategic plan or if it will be added on later. Ms. Billingsley stated that it is called out definitively in the strategic plan that there must be an evaluation of the programs. Evaluation is a key component to the granting of funds in any community setting.

Vice Chairman Pating requested, when evaluation is discussed, that the Commission's evaluation officer, Dr. Bradley, be involved to assist with the kinds of evaluations or the appropriateness of the data. The

Commission will integrate it with other MHSA data as part of the larger context the Commission is studying.

Chairman Van Horn added that, since the Commission is tasked statutorily with managing the evaluation effort statewide and aimed at quality improvement at all times, the Commission would like to be consulted during the drafting of the RFP, whether evaluation is internal in the RFP contracts or with an external evaluator.

**Public Comment:**

Stacie Hiramoto, the Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), commended CDPH and especially the OHE for their exemplary work in the community, their knowledge of the outreach process, and the trust they have secured from the people in the community. The OHE is a good model of the processes involved in community outreach that are not arduous.

Ms. Hiramoto informed Commissioners that the overarching themes in the five population reports will be contained in the strategic plan and recommended that Commissioners refer to those reports. She stated that she has not heard many complaints within the community about the length of time necessary to put together the strategic plan because the community has been informed about all of the work that has gone into it. This plan is not business as usual, but reaches the underserved communities.

**11. UPDATE: MHSOAC PAPER “CHILDREN, YOUTH, AND FAMILIES: MHSOAC PEI ACTION PLAN PRIORITIES FOR THE FIRST THREE YEARS” (ACTION)**

Deborah Lee, Ph.D., MHSOAC Staff Consulting Psychologist for MHSOAC, stated that she co-authored the original PEI paper with Dr. Saul Feldman, one of the first MHSOAC Commissioners. The Commission adopted this policy paper in 2006. The original paper was written before the PEI guidelines were released. It reflected the literature on PEI and interviews with national experts on PEI. It was based on the work of the PEI Committee and of a Commission-sponsored forum that brought together stakeholders and other experts from research, practice, and experience, to talk about what worked with PEI. The goals of the policy paper were:

- To lay out principles of PEI
- To lay out serious mental health issues that affect CYF
- To lay out the reasons why intervening early is important, useful, and effective
- To lay out areas that research showed were effective areas in which to intervene with CYF

The main update to the policy paper was in response to a request from Commissioner Correa, who has been working on a statewide response to bullying. Dr. Lee added a section on the mental health issues related to bullying as an important area in which to intervene in PEI.

It is estimated that as high as 80% of youth are involved in bullying in some capacity as victims, perpetrators, or bystanders. She noted that mental health disorders are both risk factors for and consequences of bullying, and PEI is important in both instances. Children and youth who suffer from anxiety, depression, ADHD, or physical or sexual abuse are risk factors for both bullying and being bullied.

There are very serious short- and long-term mental health consequences of being bullied. Research does not demonstrate that there are racial or ethnic differences in the likelihood of bullying. Bullying and being at risk for a mental illness are strongly correlated. Bullying that is based on a bias of some personal characteristic has more serious consequences than general bullying. Children who are in dual roles, who are bullies at times and victims of bullying at other times, have the highest consequences and have a high risk of suicide. They can be identified as early as the first grade.

There are interventions that are effective to prevent bullying and the negative consequences of bullying. Research demonstrates a definite impact from certain evidence-based practices in school, such as programs that are ecological, focus on the whole school environment, contain social and emotional learning, and use peers.

#### **Commissioner Questions and Discussion:**

Commissioner Mallel recommended, instead of at age six, that PEI begin at age three when children, for the first time, get socialized in school. She stated that age three would be prevention, but, by the time kids are age six, it would be more like intervention. Bullying can be verbal, social, physical, and cyber related. She recommended including more about what is happening in the cyber world with bullying.

Dr. Lee agreed and stated that there is a section in the expanded version of the anti-bullying paper about cyber-bullying. The research is that the effects of cyber-bullying are at least as severe, if not possibly more severe, than regular bullying. The negative effects in particular for girls are very significant for cyber-bullying.

#### **Public Comment:**

Ms. Brody stated that she strongly supports the paper. Bullying is a problem, and not only for public health and mental health. It interferes with every aspect of young people's and adults' lives. She pointed out that bullying is not only a problem for children in the schools but for adults in the workplace, and she hopes that workplace bullying will be a subject of future work by this Commission.

**Action:** Commissioner Brown made a motion, seconded by Commissioner Gordon that:

*The Commission accepts the revisions to the PEI paper, now titled Children, Youth, and Families: MHSOAC Prevention and Early Intervention Action Plan Priorities for the First Three Years.*

- Motion carried, 9-0

## **12. COMMISSIONER COMMENTS**

### **A. Discuss Future Commission Agenda Items**

Chairman Van Horn stated that Commissioner Lowenthal suggested conducting issue-oriented, workshop-type meetings, bringing in experts by subject, and reconfiguring the tables to a roundtable approach, where the speakers would be part of the circle to discuss major issues.

Chairman Van Horn suggested a possible first workshop to be the July meeting in San Francisco, and suggested "whole health" as the focus of the workshop, since the Commission is discussing integration and how all the pieces fit together, and Commissioners have not yet shared their thoughts on this

subject. He suggested inviting speakers who will help Commissioners think more carefully on the whole health issue - mental health, behavioral health, physical health, and community health - and help define what the Commission is doing to change the health of the total community and how much behavioral health impacts that change.

Chairman Van Horn suggested looking, on a workshop level, at schools and early education and the interaction and collaboration with law enforcement as future workshop subjects. He stated that Commissioner Lowenthal's approach will attract more attention from the public and will make Commissioners and the public more knowledgeable on these issues.

As part of a statewide student video contest called Directing Change, intended to prevent suicide and change minds about mental illness, high school students from across California will be honored at the Crest Theatre in an awards ceremony and screening of the winning submissions. Chairman Van Horn encouraged Commissioners to meet at the Crest Theatre to attend the ceremony today from 4:00 p.m. to 6:00 p.m.

Vice Chairman Pating asked staff to look into the clearinghouse as a location to put the information learned at the issues-specific workshop meetings. He suggested the Commission take on the role of identifying, from a state perspective, unmet needs in the state as a fourth transformation lens:

- Identifying the needs
- Involving clients and family in the needs identification and the solution
- Identifying opportunities for leverage, integration, and collaboration
- Evaluating those opportunities

This is the planning cycle that is part of every plan in all fifty-nine counties. It is a good model that the Commission should consider here.

### **13. GENERAL PUBLIC COMMENT**

There was no public comment.

### **14. ADJOURNMENT**

There being no further business, the meeting was adjourned at 3:45 p.m.