Mental Health Services
Oversight & Accountability Commission

State of California

WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meetings
September 25-26, 2013

September 25th Location:
MHA Village
456 Elm Avenue
Long Beach, California

September 26th Location:
Westin Long Beach
333 E Ocean Boulevard
Long Beach, California

866-817-6550; Code 3190377

Members Participating

Richard Van Horn, Chair
David Pating, M.D., Vice Chair
Khatera Aslami-Tamplen
John Boyd, Psy.D.
Sheriff William Brown
John Buck
Assemblymember Bonnie Lowenthal
LeeAnne Mallel
Christopher Miller-Cole, Psy.D.
Ralph Nelson, Jr., M.D.
Larry Poaster, Ph.D.

Members Absent

Victor Carrion, M.D.
Senator Lou Correa
David Gordon
Paul Keith, M.D.
Tina Wooton

Staff Present

Sherri Gauger, Executive Director
Aaron Carruthers, Chief Deputy Executive Director
Kevin Hoffman, Deputy Executive Director
Filomena Yeroshek, Chief Counsel
Jose Oseguera, Committee Operations Chief
Norma Pate, Administrative Chief
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 2:13 p.m. on September 25, 2013 and welcomed everyone. Chief Counsel Filomena Yeroshek called the roll and announced a quorum was not present.

Chairperson's Remarks

Chair Van Horn shared the background of the founding of Mental Health America (MHA) Village, where the meeting convened today.

The building was built in 1922, damaged by an earthquake in the late 1930s, and gradually rebuilt. It became the site of the program in 1989.

When several family members took complaints about how their children were treated to the lieutenant governor, asking for investigation of Los Angeles mental health, one of the governor's advisors suggested instead asking for a better program. A task force was formed.

They looked at Fountain House in New York, the capital funding mechanism in Rochester, thresholds in Chicago, independent centers in St. Louis, and original certification programs in Madison. Since none of these programs were complete, they asked Kathy Wright to write a bill to blend elements of each program.

Modesto received the rural pilot, and Long Beach received the urban pilot - the Mental Health America of Los Angeles (MHA) Village. MHA Village began hiring, including Joe Ruiz, who had been dealing with homeless outreach in Long Beach for three or four years prior. This program and its development led to Proposition 63.

2. FULL SERVICE PARTNERSHIP MINI-IMMERSION

Joe Ruiz, the Director of Training and Workforce Development of MHA, welcomed Commissioners to MHA Village. He has been with MHA for twenty-seven years. The history of MHA Village progressed in segments with definite outcomes.

1989-1993 - The Wonder Years

In the beginning, MHA Village had little guidelines other than “figure out what works” and “don’t go broke.” Assembly Bill (AB) 3777 was the four-year pilot project, which gave MHA Village only a short time to accomplish its work.

Independent Evaluation

There was independent evaluation attached to the pilot to determine if the integrative approach was better than the usual system of service. The independent evaluator, Joan Meisel, who recently wrote the MHSOAC Evaluation Master Plan, looked at two groups of people - a group randomized into the pilot and a control group.

Legislative Mandates

Some key pieces were written into legislation as the program developed:

- Services had to be client or member driven. There was to be nothing done without the member’s approval. The usual system of service required members to do what was available; the MHA Village pilot project committed to do what members wanted and needed.
- There had to be a psychosocial rehabilitation focus. The program could not be set up as a maintenance program, but instead had to promote growth and learning to help people move forward.
- There had to be a single point of responsibility - a key name, one number to call, and one place to go.
- There had to be multi-disciplinary or multi-talented service teams to figure out the best approach.
- There was a quality-of-life outcomes focus. MHA Village had to show there were outcomes and the results of their efforts, such as education, employment, and social connections. They were to report as changes occurred in someone’s life.

1993-1996 - Partners in Crime

During this era, MHA Village became directly involved with the Los Angeles County Department of Mental Health (LACDMH) via contract. Prior to that, admission criteria included a diagnosis for mental illness, which had affected the individual's life in some way, and a history of hospital stays. The county sent twelve high users to MHA Village.

At that time, MHA Village outcome measurement tools were adopted by LACDMH. Its system was not previously used to collect quality-of-life outcomes. The fact that the county adopted the outcome measurement tool moved more towards outcome orientation and accountability.

1996-1999 - The Camel Gets in the Tent

Mr. Ruiz stated that MHA Village's direct relationship with the state and state funding ended in 1996. Its funding authority shifted to LACDMH as a result of realignment.

As a result, the county determined that MHA Village was too small and needed to increase enrollment. It was then serving 120 people. MHA Village went from 120 to 276 in about thirteen months.

Mr. Ruiz stated that in that thirteen-month period of time, MHA Village lost the relationships that it was able to foster with a smaller group of people over time, and was suffering because of it.

Then, the county decided to utilize service use as the enrollment criteria. A person would have had to cost the county a certain amount of money in the previous years in amounts of services in order to be eligible. People were placed into one of two bands, depending upon service use. Both bands received the same services. In 1996, the first year of MediCal, MHA Village offered two rates - the moderate rate for clients who did not need much service and the high rate for newer clients.

1999-2004 - Immersions, Diversions, and other Excursions

In this period of time, the language of recovery became more prominent. Prior to that, it was psychosocial rehabilitation. Dr. Ragins's writings on recovery and the stages of recovery fueled that shift of language and orientation towards a recovery focus.

During this time, AB 34 and AB 2034 came into play. AB 34 was a pilot made of three different counties, and AB 2034 went statewide and used different criteria for looking at who they served. Three new target groups came into play: the homeless, the formerly incarcerated, and those aging out of the youth system.

MHA Village tried to build its process into a system of flow, so graduates could return if they needed to. MHA Village worked with LACDMH to give previous enrollees priority in being reenrolled. This alleviated the fear that graduates would be left on their own.

The outcome measurement tool began its statewide use through AB 2034 to collect information on AB 2034-funded programs, primarily quality-of-life outcome information, which had become more accepted. Since people were no longer afraid that reporting negative outcomes would cause them to lose funding, it opened the door for outcomes measurement and AB 2034 to go statewide.

The final AB 2034 statewide outcomes showed, between the year before and the year since enrollment, 64.6 percent reduction in psychiatric hospital days, 81.25 percent reduction in incarceration days, 76.41 percent reduction in homeless days, and 161.96 percent increase in employment days.

2004-2009 - Taking Initiative

Mr. Ruiz stated that the passing of Proposition 63 in 2004 became the beginning of the Mental Health Services Act (MHSA). One of the key things that graduates needed, if they were not working or did not have behavioral health coverage on their jobs, was continued psychiatric care. MHA Village searched for a good psychiatrist in the community who took MediCal, and ended up creating a wellness center as a result, where people could check in for medical service, resources, and so on. This helped to build lives beyond MHA Village, which then became more of a resource and check-in service.

The End of AB 2034

Governor Schwarzenegger decided to blue-pencil the $51 million funding from AB 2034. This was unfortunate because, as evidenced by the statistics and outcomes, it was a highly effective program on a statewide basis, in a broad number of venues.

Beginning of Full Service Partnerships

As MHSA came into being, the term became Full Service Partnerships (FSPs) instead of integrated service agency. FSPs were the result of the previous years of efforts and learning.

Chair Van Horn added that another important thing was the state's decision to take over the outcome collection and analysis.

Where are we going?

Mr. Ruiz stated that MHA developed its outcomes instrument, the Milestones of Recovery Scale. It is an eight-point instrument that measures where a person is in a recovery process. MHA Village trains on and uses it to measure its influence on the larger system.

MHA Village principles were created in 1992, and updated in 2009-2010 to stay fresh, new, and relevant. For any organization, it becomes easy after a while to just rest and be comfortable. It is something else to continue pushing forward to new and different directions.

Vision for the Future

The people who work in MHA Village are not only mental health providers but social activists. Their prime mission is social justice, to ensure that people experience equality in the larger community. Recovery is the expectation. MHA Village is an innovative leader, trying new ideas and taking an updated perspective on existing ones.

Dr. Ragins stated that forty-six of the fifty-eight counties have been reached. Community inclusion is the cornerstone of recovery. Stigma will only break down by individual stories of recovery and people connecting with their community. A strong aspect of MHA Village's vision is to encourage and foster that growth, connection, and inclusion of the people it serves.

Mr. Ruiz stated that Dr. Ragins was the first psychiatrist that MHA hired as part of MHA Village. He works with people one-on-one on his own time to help them figure out how to better live their lives with or without his involvement, and has been the one to push MHA Village's thinking further.

Dr. Ragins added that he has travelled around the country and internationally to speak about recovery. He shared the three biggest transformations, which are not intuitive and have shifted dramatically.

The first transformation is the shift from illness-centered to person-centered. His job is not to treat mental illnesses but to help people with mental illnesses to have better lives. This outcome-centered perspective changed his approach; his first step is now to build a relationship

rather than to do an assessment. He engages his clients and asks them what goals they want to pursue. Clients visit MHA Village for work and socialization opportunities. There is always something that can be done to better a client's life, even if that client cannot be cured.

This changes what the outcomes are, what the relationship is, what the goals are, who is important, who money is spent on, how money is spent, and where the focus lies.

The second transformation is the shift from professionally-driven to collaborative- or client-driven. MHA Village does not control or punish its clients, instead collaborating and sharing decision making. While MHA Village pushes people to strive to be healthy and avoid dangerous behavior, it also complies with their goals. Staff combines poverty services with mental health services without complaint.

The third transformation is the shift from deficits-based to strengths-based. Strengths-based does not mean smiling and fixing what is wrong; it means nurturing and building on what worked and what brought people through.

Protective factors are more important than risk factors. Protective factors include housing, finances, family, a role in life, and spiritual beliefs. Every individual admitted to the hospital has one or more of those five things. Instead of trying to fix what might be a treasured part of someone's life, building on their strengths helps them to develop resilience.

Recovery is the process clients, not mental health workers, go through. To truly help someone depends on seeing the world from his or her perspective.

3. PREVENTION AND EARLY INTERVENTION AND INNOVATION OVERVIEW

Chair Van Horn stated that the Legislature wrote requirements for outcomes and evaluations into Realignment 1 in 1991. There was nothing done about prevention and early intervention (PEI). Proposition 63 set aside twenty percent of all dollars for PEI. Chair Van Horn added that it should not be PEI but P and EI, because prevention and early intervention are two different programs.

In 2007, the Commission passed guidelines around PEI, but had never written regulations for it. Now, MHSOAC is obligated to come up with regulations. The first draft has been written. Commissioners will see the basic principles during tomorrow's meeting; the first read for the complete set of regulations will be on October 24th, 2013, and the second will be at the November, 2013, meeting. After the Commission passes it, there will then be a public comment period.

PEI was written into Proposition 63 intentionally. It is one of two areas that the Commission has control over. PEI is twenty percent and Innovation (INN) is five percent from PEI, and five percent from Community Support Services (CSS). PEI and INN were brand new concepts coming into Proposition 63. Five percent of funding for INN has been set aside for the purpose of redesigning and transforming the system.

<u>Presentation</u>

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist, stated that Dr. Ragins mentioned both PEI and INN in his presentation earlier. He talked about the catastrophic consequences when mental illness is not addressed and about the need to innovate. One of the most important things about PEI is to go to help first.

The MHSA states that PEI shall be a program to prevent mental illnesses from becoming severe and disabling, and to emphasize improving timely access to services for underserved populations. There are varieties of components that need to be included. Some are direct

services early in the phase of the mental illness, such as outreach, which teaches ways to identify early signs of mental illness. Others are linking functions to include access to necessary care provided by mental health programs as early as possible. Reduction in stigma and discrimination associated with a diagnosis of mental illness or seeking mental health services is also necessary.

MHSA also states the program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

MHSA goes on to state the program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. PEI funds may be used to broaden community-based mental health services by adding PEI activities to other things.

No other state has made this kind of investment in PEI. There has been increased focus on PEI and research documenting its power. PEI is one of Substance Abuse and Mental Health Services Administration's (SAHMSA) eight priority strategic initiatives; the Institute of Medicine and the National Association of State Mental Health Program Directors published studies related to PEI; the World Health Organization (WHO) has been a leader on focusing on PEI; and MHSOAC wrote a paper on effective PEI practices for children and youth. The Commission is part of and contributing to a larger effort.

Myths about PEI Structure

- PEI can fund general community wellness or broad social services. Wellness as a goal is important, but it is not allowable in the guidelines without there being either risk or early onset.
- There is no requirement for outcomes. Every PEI program is required to define mental health outcomes and to specify what the evidence is. There has to be evidence that what they are doing is likely to bring about those outcomes.
- PEI funds cannot be used for individuals diagnosed with a mental disorder. The guidelines differentiate prevention individuals as risk compared to early intervention individuals as early onset.
- Serious mental illness, for the most part, cannot be prevented, but it is without question that many of the devastating consequences of serious mental illness can be prevented.

There is a current PEI evaluation, which this Commission has supported, that looks at how and to what extent PEI funds are being used. The other part of that study is to look at three clusters of early intervention efforts for their collective impact: older adults with early-onset depression; children and youth with early-onset of emotional disturbance as a consequence of trauma; and first break psychosis.

Dr. Lee added that the outcomes of early intervention for older adults is reduction of depression. For emotional disturbance as a consequence of trauma, they are looking at recovery inventories. For the onset of psychosis, they are looking at reduction of symptoms, employment, and educational and family outcomes. They go through the seven negative outcomes in MHSA and look at the subsets that apply to each situation.

Commissioner Questions and Discussion:

Commissioner Nelson asked if they are looking at the methods of treatment. Dr. Lee answered that they are, in all the clusters.

Vice Chair Pating asked if the seven negative outcomes are part of each MHSA component.

Dr. Lee answered that the seven negative outcomes are contained in PEI section. They are not contained in MHSA as a whole, except to the extent that PEI section is in MHSA.

Vice Chair Pating asked if they are in CSS. Chair Van Horn stated that outcomes from CSS come back from Realignment 1 as outcomes that were originally designed for MHA Village pilot program under the system of care. Those outcomes are since grandfathered into MHSA, because there are still required outcomes in the system of care. The only thing that was added are the seven negative outcomes that are in MHSA itself in PEI section.

Vice Chair Pating asked for clarification regarding negative press about PEI related to a misunderstanding of the purpose of PEI funds. Dr. Lee answered that it is important to know what MHSA says about PEI. One of the key purposes is to link people who need treatment to that treatment by getting them to do therapeutic activity, to connect with people, and, through that, to connect with other things so that the subsets that require treatment will get treatment. The other purpose is, in a recovery-focused treatment system, to connect and participate in culturally appropriate therapeutic wellness activities.

A Commissioner asked if Dr. Lee considered this to be more community-based practices that are being migrated into evidence-based practices.

Dr. Lee answered that, when people with serious illness and co-occurring disorders are being helped in a nontraditional way, the effects are powerful. However, the same range of nontraditional methods in PEI can drift if there is not a clear sense of intended outcomes. The context of certain practices has been misunderstood.

The important thing to remember for PEI is that MHSA talks about people with or who are at risk of a serious mental illness. Then, there are linking functions to deal with stigma and discrimination that go across the continuum. In an outcomes-focused approach in a Commission that has decided that evaluation is its predominate approach to oversight and accountability, the idea is to examine outcomes to ensure people are being served. How that will be done may look unusual.

Another lesson learned is the other strategy this Commission has adopted, which is support. Ensuring that counties have the support they need and supporting more than training and technical assistance (TA) go hand in hand.

Chair Van Horn stated that one of the things that was important for MHA Village was communicating that the work done there was about people. Staff had to learn not to worry about their professionalism but to worry about the people they served, and to help them put their lives back together.

<u>Innovation</u>

Dr. Lee stated that there are two big opportunities for INN. On a system level, INN is the place to bring in new practices. It allows the counties to try something out that they are not ready to fully commit to, and allows them to take a manageable risk that, if successful, has the potential to make a big difference.

The requirements for INN were grandfathered in from CSS and are in MHSA. INN funds an evaluation for running a program, not funding for a program to be evaluated.

The long-term goal for INN is not to meet a service goal, but to find out how to meet that service goal. It is clearly a different kind of effort, and people need to make that shift in understanding. When that shift in understanding is made, the community gets excited about it because there is the opportunity to really innovate.

INN funds the conceptualization, design, piloting, assessment, and evaluation of an INN idea. Then, the decision of whether or not to continue it is made.

MHSA states the goal of INN is to increase access to underserved groups, increase access to services, promote interagency and community collaboration, and improve the quality and outcome of services. It must be either brand new or an adaptation and must be consistent with MHSA - focused on mental illness, risk, early onset, developmental illness, or recovery. The funds derive from PEI and CSS but are not limited to that.

4. CLOSED SESSION - GOVERNMENT CODE SECTION 11126(a) RELATED TO PERSONNEL

Chair Van Horn recessed the September 25th, 2013, meeting at 5:54 p.m. and moved Commissioners into a Closed Session. The meeting will reconvene tomorrow at 8:30 a.m.

Thursday, September 26, 2013

5. ANNOUNCEMENTS

Chairman Richard Van Horn reconvened the meeting at 8:34 a.m. on September 26th, 2013, and summarized the upcoming agenda. Administrative Chief Norma Pate called the roll and announced a quorum was present.

Chair Van Horn introduced new Commissioner Christopher Miller-Cole.

Chair Van Horn reported that the closed session last night did not have any reportable actions. Although there were no actions taken, Commissioners did discuss succession plan issues, since Executive Director Gauger will retire on December 30th, 2013 Chair Van Horn thanked her for her contributions to MHSOAC.

Chair Van Horn stated that Commissioner Poaster will chair the Screening Committee; the finalists for the executive director position will come before the full Commission in November.

6. WELCOME

Marv Southard, the Director of LACDMH, welcomed the Commission to Los Angeles County. He stated that the Voice Awards the previous night highlighted the progress that has been made in mental health. The difference between the way clients have been and are currently portrayed is a mark of the achievements of clients and advocates. He thanked the clients in attendance for contributing their insight to Commission meetings.

Dr. Southard stated that the resources MHSOAC oversees have already played a key role in preparations for the implementation of the Affordable Care Act (ACA) in January, ensuring that mental health services will be well-integrated with physical health and substance abuse services. PEI and outreach work the Commission helps to fund also play a role in creating a new vision for providing care. However, integration must extend beyond services; healing takes place in the context of a community. MHSOAC's PEI and outreach work will enable communities to be empowered to address the "social determinants of health outcomes" by using MHSA resources to focus on strengthening communities. Dr. Southard welcomed the Commission's partnership in this opportunity.

7. APPROVAL OF JULY 25, 2013, MHSOAC MEETING MINUTES (ACTION)

Commissioner ~~Boyd~~ Buck pointed out the fourth line on page fifteen, states, "Veterans living with mental illness make up twenty percent of the state prison inmate population before October 1st." Although the California Department of Corrections and Rehabilitation (CDCR) has, on two occasions, quoted over twenty percent of the inmate population as having severe psychiatric disabilities, he did not believe the use of "veterans" was correct in this situation.

Chief Counsel Yeroshek clarified that the quote was made by a member of the public and is not verified.

Action: Vice Chair Pating made a motion, seconded by Commissioner Brown, that:

MHSOAC adopts the minutes of the July 25, 2013, MHSOAC Meeting with the acknowledgment of a factual error made by a member of the public.

- Motion carried, 10-0

8. ELECT CHAIR AND VICE-CHAIR FOR 2014

Filomena Yeroshek, MHSOAC Chief Counsel, briefly outlined the election process and asked for nominations for chair of MHSOAC for 2014.

Action: Commissioner Poaster made a motion, seconded by Commissioner Brown, that:

The Commission reelects Chairman Richard Van Horn as chair of the Mental Health Services Oversight and Accountability Commission for 2014.

- Motion carried, 10-0

Chief Counsel Yeroshek asked for nominations for vice chair of MHSOAC for 2014.

Action: Commissioner Poaster made a motion, seconded by Commissioner Brown, that:

The Commission reelects Vice Chairman David Pating as vice chair of the Mental Health Services Oversight and Accountability Commission for 2014.

- Motion carried, 10-0

9. INNOVATION PLAN APPROVAL (ACTION)

A. Amador County

Jose Oseguera, MHSOAC Chief of Plan Review, stated that Amador County has requested $135,000 for a three-year INN program entitled "Plymouth Wellness Day." Amador County Behavioral Health Services proposes a collaboration between public mental health and the transit authority to provide underserved groups with access to behavioral health and PEI services. The project also has an evaluation component through participant satisfaction surveys and transit utilization data. The Warwick-Edinburgh Mental Well-Being Scale will be used to determine how the services affect participants.

Vice Chair Pating referenced the conversation from the previous day, which emphasized the importance of INN programs being understood by the public. He recommended an informative title and a clear purpose to build access.

Plan Review Chief Oseguera stated that the area is a rural community with both behavioral and physical health facilities that will be accessible from outlying areas through these transit services. The title can be modified.

Commissioner Boyd asked what the expected number of individuals using the transit might be. Plan Review Chief Oseguera answered that the county will conduct extensive surveys of rural communities to determine how many individuals use transit services to seek the behavioral and physical health opportunities that will be provided in a centralized location.

Commissioner Boyd asked if that is a part of this INN request for funding in terms of volume, or if those transit services existed in another form and have been successful in the past.

Plan Review Chief Oseguera answered that the service is considered novel for this county. There is no information yet on volume of passengers. The county hopes to capture that information once the services have begun. The INN plan provided information without statistics on the need identified in that area: the outlying communities that could not access services.

Commissioner Boyd asked if there was any requirement for data or analysis for programs like these to justify the work and expense. Chair Van Horn answered that this is the first time MHSOAC has received a request of this nature. Studies must be done to determine how many people live in the area; if there is sufficient traffic, the route will be picked up by either Amador County Mental Health or the transit service. There will be periodic reports.

Commissioner Aslami-Tamplen asked what kind of outreach will be done to the community to inform them about the availability of services. Plan Review Chief Oseguera answered that they will work with peer groups and stakeholders to do outreach regarding both the new transit and the services themselves.

Commissioner Poaster stated that his concern over the title of the project and recommended increasing the emphasis on accessibility, as clarity of intent is important. Plan Review Chief Oseguera answered that this proposal not only allows for access but also the integration of services.

Commissioner Buck stated that he assumes Amador County vetted the proposal publicly and properly and will reach a valuable number of individuals through the project. The social isolation in rural areas can be devastating; he remained hopeful that the INN plan would evolve to best complete its purpose.

Plan Review Chief Oseguera answered that this project went through an extensive community planning process, which engaged various individuals in the community to determine if these services were necessary.

Vice Chair Pating asked Plan Review Chief Oseguera to explain MHSOAC plan review process. Plan Review Chief Oseguera answered that, once staff receives the plan, they analyze it and provide technical assistance to that county. Any flaws are resolved with the county before the plan goes through the approval process.

Commissioner Lowenthal asked if it will take three years to determine if the plan works and attracts people who need services. Plan Review Chief Oseguera stated that the surveys will begin as soon as the service is in place. Based on the number of individuals using the transit facilities, they will develop data regarding the ridership.

Commissioner Lowenthal asked if an approved time limit would remain in place even if data showed the transit to be insufficiently used. Plan Review Chief Oseguera answered that the pilot is intended for three years; the evaluation component determines whether this is a viable project to be further funded in the future.

Commissioner Boyd expressed his concern over the lack of data or analysis supporting the three-year pilot.

Commissioner Poaster asked if the projects are subject to annual updates that will incorporate the data of the previous year, and if there is a way to show progress, such as through reporting.

Dr. Lee confirmed there is an annual update and report on the use of the funds, the numbers served, and so on. Staff reviews all of the components to assess whether or not the program is proceeding as expected. She clarified that the program was developed through a community planning process, which included projections that the program would increase access for people at risk.

Staff provides extensive TA to counties; in this case, it was late in the process, but the essence of that assistance was to ensure there was a focus on risk or early onset of serious mental illness. Initially, the plan viewed the entire community as being at risk, but staff asked that the conception and evaluation of the project focus specifically on individuals who are at risk or with early onset of mental illness. Even though it is a community-based approach, the hypothesis in INN shows this as the best way to address that population.

With regard to INN, there are certain requirements: it must be an untried approach that focuses on mental illness and addresses the four purposes in MHSA. Other than these requirements, the plan is flexible.

Commissioner Nelson stated that a rural, isolated area will require continued outreach for years in order to show success or failure.

Commissioner Brown stated that the proposal implies the transit system will serve not only the at-risk individuals but the community as a whole. He was concerned by the lack of specificity and background information. The population of the community is 379, according to the latest census. It is fifteen miles from Amador City. He did not feel the amount of funding available could cover a general cost without concrete data.

Dr. Lee clarified three points: there is more detail about people lacking in mental health services in the documentation for the plan; the funding will cover not just transportation but also mental health screening and PEI services in the community; and the proposal is not intended for funding for a service but for testing an increased collaboration with transportation services, with a future potential of expanding to other sources of funding.

Commissioner Aslami-Tamplen asked if there is a specific training in recovery and wellness for the bus drivers on this route. Dr. Lee answered that there is not, to her knowledge, and it is a good suggestion. There will be increased representation of Amador County in the next Commission meeting to better answer Commissioners' questions.

Vice Chair Pating recommended repackaging the plan to more clearly combine all of the services in town for a wellness day.

Vice Chair Pating stated that much of the balancing of needs is done with the robust community planning process at the county level, where the first needs assessment occurs. Next, staff checks that the initiative meets the INN guidelines. Then, the Commission verifies that the initiative falls under MHSA and gives feedback.

Action: Vice Chair Pating made a motion, seconded by Commissioner Mallel, that:

The Commission approves Amador County's Innovative Program contingent on the adjustment of the name to ensure it is within MHSA purview.

- Motion carried, 11-0

10. PEI AND INN REGULATIONS CONCEPTS AND PRINCIPLES

Executive Director Gauger stated that AB 82 was signed by the Governor on June 27th, 2013. The bill went into effect immediately and required the Commission, for the first time, to issue and adopt regulations for both program and expenditures of INN and PEI funds. The Commission formed a workgroup, consisting of three members from each of the Commission's five standing committees. The workgroup held two meetings open to the public; in the August meeting, staff presented a suggested approach and framework for developing regulations. With the input from the workgroup participants, staff drafted the regulation language. The workgroup met again last week to review and give additional input on the language, which will be presented to the Commission in October.

Staff's approach to drafting the regulations was to ensure they stayed within the law that controls the regulatory process at the state level, the Administrative Procedures Act, which limits regulations to interpretation, clarification, and implementation of statute - in this case, MHSA. Executive Director Gauger referred to matrices for PEI and INN in Commissioners' packets that chart the sections of the law, terms, and staff suggestions for clarification. The Administrative Procedures Act encourages the provision of performance standards and outcomes focus, which is consistent with MHSA. The workgroup strove to remain flexible in its support of county and community priorities.

Dr. Lee stated that there are a few specific provisions in MHSA about what is required for PEI. The overall purpose for PEI, according to MHSA, is to prevent mental illness from becoming severe and disabling. This leads to two different approaches: specific programs addressing the needs of people at risk of or with early onset of serious mental illness, and broader efforts to link people to services, including treatment.

The first key purpose for PEI in MHSA is early intervention. MHSA states PEI is to reduce the duration of untreated severe mental illness. Early intervention programs are intended for individuals with early onset of a serious mental illness.

The second key purpose for PEI, as a program strategy, is approval of timely access to services for underserved populations. Staff felt that all PEI programs had the opportunity to do this and therefore required all programs to include this strategy and to provide data to indicate progress.

The next component of the Act is to provide outreach to families, employers, primary care health providers, and others, to teach them to recognize the early signs of potentially severe and disabling mental illness. One of the workgroup participants pointed out that individuals can recognize their own signs and symptoms, and should be included in this definition. Staff felt that this purpose could be achieved either as a standalone effort or as a component of other programs. It is important that all counties do this while still remaining flexible about the way in which they do it.

The next required element is access to medically necessary care for children, adults, and seniors with severe mental illness as early in the onset as possible. This means finding people who have severe mental illnesses as early as possible, to ensure people who need treatment receive it as early as possible. Staff felt identifying people who need ongoing treatment is mainly a strategy for programs to include, but could, in some instances, be a standalone effort.

The last element staff felt is required for all programs is the reduction of stigma and discrimination associated either with being diagnosed with a mental illness or with seeking mental health services. All PEI programs must be accessible and offered in non-stigmatizing ways, including multiple stigmas.

In addition, staff identified optional strategies. Prevention, or interviewing at a clearly-defined point of risk of a serious mental illness, and offering services can help to prevent mental illness from becoming disabling. Also, many counties have made broad efforts to reduce stigma and discrimination and to prevent suicide.

The key change staff recommended in the draft regulations was a greater focus on evaluation and reporting outcomes. Currently, all counties are required to define outcomes for their PEI programs, but not to measure them. Staff is working to define outcomes as the first step towards an integrated approach to evaluation. For the individual PEI programs, it is important at this stage to let counties define their own outcomes, but to have each of those outcomes link to the seven negative outcomes in MHSA in order to move towards a more consistent outcomes framework.

With INN programs, the key is to learn how to meet a service goal. INN programs are intended to be experimental opportunities and require few things in MHSA. An INN program must be a new approach for the mental health field, an adaptation of a current mental health practice, or a community practice shown to be effective in other contexts. INN funds are intended for the design, piloting, and evaluation of these new or changed practices and for the decisions of how to incorporate them into existing services in an ongoing way, using other sources of funding if needed.

The requirements for INN programs are already in MHSA. The main thing staff proposed is to strengthen the final report with more detail about outcomes and lessons learned.

Chief Counsel Yeroshek stated that, once they had the framework, staff drilled down to the terms of MHSA that needed to be defined or clarified. They developed the matrices to illustrate the process. For example, MHSA states PEI programs are required “to include services similar to those that are provided under other programs effective in preventing mental illnesses from becoming severe.” Staff suggested that “effective” be defined by the county as demonstrating using an evidence-based practice or a community-defined practice. The practice must achieve mental health outcomes.

As another example, MHSA provides that, if an INN project is proven successful and a county chooses to continue it, the county has to transition to another funding source if appropriate. AB 1467 required counties to demonstrate a partnership with constituents and stakeholders throughout the process, including program planning, implementation, monitoring, quality improvement, evaluation, and budget allocation. Staff suggested that this regulation make it clear that the county’s decision to continue a successful INN project involve stakeholders.

Staff’s next steps will be to present a draft of proposed language for the regulations to the Services Committee on October 11th, which will be open to the public. Then, staff will consider comments and feedback received and bring the draft regulations to the Commission on October 24th. Staff will make any changes, bring the draft back for a second read and proposed adoption on November 21st, and then start with the Office of Administrative Law process to issue the regulations. There will be a forty-five-day general comment period. There may be a need for the Commission to meet at the end of that period and, depending on the comments received, the regulations may be revised; if revisions are drastic, the draft will go back to the Commission and may require another public comment period. The goal is to roll out the regulations by late spring of 2014.

Commissioner Questions and Discussion:

Commissioner Lowenthal stated her appreciation for the work staff has done on this. She asked, as counties develop evaluation, if that evaluation will be standardized, particularly between rural and urban areas.

Dr. Lee answered that one of the Commission's first Commissioners, who was passionate about PEI and evaluation, advocated an integrated evaluation system to match the integrated approach. The Evaluation Master Plan is working towards integration. MHSA requires a performance outcome system, which the Commission is working on with the Department of Health Care Services (DHCS) and others. For the programs that serve individuals, counties can select their own indicators but tie each one to one of the seven negative outcomes. The other oversight and accountability strategy besides evaluation is support for counties so they have resources available to move towards common methods. At this point, it is not practical to require specific outcomes. Staff still hopes to define a few common indicators in the future.

Commissioner Nelson confirmed that questions on the matrices can be submitted by e-mail, and asked if the Commission reaches the same people during open comments as are reached in the forty-five-day comment period after the regulations are approved. Chief Counsel Yeroshek answered that some of the same people will be reached, but many new people will be, as well.

Commissioner Aslami-Tamplen stated that the regulations are similar to traditional medical model language, when PEI and INN gives an opportunity to use recovery and wellness language. She suggested promoting functional outcomes instead of trying to prevent negative outcomes. Chief Counsel Yeroshek stated that the draft regulations include different language.

Commissioner Poaster asked if "underserved populations" are defined in MHSA. Chief Counsel Yeroshek answered that the term is defined in the current regulations, under Title 9, Section 3200.300.

Vice Chair Pating asked for clarification of whether staff is translating MHSA into regulations. Chief Counsel Yeroshek confirmed staff is in the process of this.

Vice Chair Pating asked the Commission to look at the evaluation framework that will be incorporated and consider whether it needs to seek legislation or expand what is contained in the evaluation component. He stated that the audit was clear: the evaluation needs to be strengthened. He felt the regulations from 2004 were not substantial enough guidance to produce PEI outcomes in the next two or three years that can be reported in the next audit. He encouraged the Commission to be specific.

Chief Counsel Yeroshek stated that staff has been working extensively with Dr. Renay Bradley, MHSOAC Research Evaluation Director. The draft language that will be presented in October will have a great focus on evaluation. The regulations will offer much more guidance than they have in the past.

Public Comment:

Charles Hughes, of Advocates in Action, encouraged Commissioners to keep the core values of the regulations in their new interpretation going out to the counties.

Don Kingdon, of California Mental Health Directors Association (CMHDA), stated that, while his organization acknowledges the importance of quality in outcome measurement, they do not believe the regulatory process is the appropriate vehicle for this level of detail. First, regulations are difficult to modify; second, regulations with high administrative requirements and cost will be subject to local government mandates and Proposition 1A review; and finally, regulations must be applied equitably across all counties, but resources do not. This must be workable for all counties.

Jason Robison, of Self-Help and Recovery Exchange (SHARE), stated his interest, as regulations move forward, in the consumer and family member participation process. He recognized that it is a difficult effort to integrate how that happens. As plans, evidence-based

practices, and community-based practices are assessed, involving transparency is very important. He encouraged the Commission to examine how stigma and discrimination infuse the systems of care and to train people to come into the system with wellness and recovery language and practices in mind.

Gwen Lewis-Reid, a consumer and advocate, encouraged the Commission, while expanding PEI and INN programs, to remember that client-run programs have been accepted by SAMHSA best practices, based on research. Client-run programs are cost effective and have positive outcomes for clients. She mentioned the Hacienda of Hope in Los Angeles, a respite center for clients with pending hospitalization, which has been very successful. The key is for programs like this to be retained.

Stacie Hiramoto, the Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked Commissioner Poaster for asking about the definition of "underserved populations." The current definition has not served racial, ethnic, or other cultural communities well, as it does not promote or encourage counties to develop programs or approaches that target underserved racial, ethnic, or cultural communities. She stated her hope that this will be addressed, and that the notion of reducing disparities be included in that.

Bill Wilson encouraged the inclusion of peer advocates working in recovery.

Sally Zinman, with the California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated that she misses the values and principles that were in the guidelines of the old Department of Mental Health for PEI and INN. She added that this should be used to inform the new regulations and asked the Commission to consider those values in the future.

Suzanne Hanna, representing Vet to Vet of Greater Los Angeles and co-author of the California Reducing Disparities Project (CRDP), stated that, as they move forward with programs to help veterans, counties are often at a loss for well-trained people with cutting-edge, evidence-based approaches to involving family members. She emphasized that accountability and evaluation needs to target and empower providers to involve families at a deeper level.

Debbie Innes-Gomberg, with LACDMH, MHSOAC Evaluation Committee, and Team HDA, stated that the evaluation of PEI is critical, but, first and foremost, it should support county efforts at quality improvement. It should also be considered in the overall evaluation of the public mental health system. She advocated for a more flexible timeframe for early intervention - eighteen months, due to the necessary outreach engagement and interventions that take more than twelve months.

Vice Chair Pating asked Ms. Innes-Gomberg if there are concrete ways to find a balance between the state needs for reporting and the local needs for collection. Ms. Innes-Gomberg answered that there are several counties that could work with MHSOAC and DHCS to create accountability and quality improvement. It is important that the data at the local level be used to minimize suffering.

11. BUILDING AN INTEGRATED HEALTH SAFETY NET WITHIN A COMMUNITY ROUNDTABLE

A. Subject Matter Experts

Patricia Costales, Executive Director of The Guidance Center

Brian D'Andrea, President of the Century Villages at Cabrillo

Mariko Kahn, Executive Director of the Pacific Asian Counseling Services

Elisa Nicholas, M.D., CEO of The Children's Clinic, Serving Children and Their Families

David Pilon, Ph.D., President and CEO of Mental Health America, Los Angeles

Alan Terwey, Executive Director of the Westside Neighborhood Clinic

Michele Winterstein, Ph.D., Executive Director for The Child

Chair Van Horn introduced the members of the panel for the second bimonthly roundtable discussion to introduce new topics and new concepts to the Commission. Today's topic is on how to construct a safety net for a community.

David Pilon, Ph.D., the President and CEO of Mental Health America, Los Angeles (MHALA), stated that the group's working title is the Long Beach Safety Net Consortium, a group of seven organizations seeking better ways to coordinate care. One of the reasons Dr. Pilon is interested in this process is that so many people his agency serves, primarily adults with severe and persistent mental illnesses, have co-occurring, co-morbid conditions, shortening their life spans by up to a quarter of a century.

About a year and a half ago, he attended a conference, hosted by the California Endowment, Parsons, and Weingart Foundations, called the Non-Profit Sustainability Initiative, which addressed collaborations and efficiencies between non-profit organizations. Dr. Pilon's agency reached out to Dr. Nicholas and Serving Children and Their Families, but the consortium needed to expand even further to cross age groups, think about health holistically, and include services that are not traditionally considered part of health, such as housing.

The Consortium received a grant by the California Community Foundation to collaborate to care for the underserved populations in Long Beach. The process has just begun; the first meeting took place about a year ago. The panel introduced themselves at this time.

Elisa Nicholas, M.D., the CEO of The Children's Clinic, Serving Children and Their Families, stated that her organization was founded nearly seventy-five years ago and provided 105,000 visits at eight sites throughout Long Beach last year. This is a great opportunity to look at how to integrate mental and physical health services. She follows WHO definition of health as a state of physical, mental, social, and spiritual well-being.

Brian D'Andrea, the President of the Century Villages at Cabrillo (CVC), stated that his organization owns, develops, and manages the Villages at Cabrillo community in Long Beach. CVC is the affiliate of Century Housing, a larger non-profit organization that engages in the financing and development of affordable housing throughout California. CVC is a twenty-seven-acre supportive housing community with more than a thousand formally homeless residents, including veterans of all ages and families with children. CVC exists to break the cycle of homelessness through collaboration with twenty non-profit and government agencies. Their goal is to create an environment where people can become well and begin to think of the future. CVC has another eighty units of permanent supportive housing planned that will start construction later this year, and another four acres they intend to develop soon.

Mariko Kahn, the Executive Director of the Pacific Asian Counseling Services (PACS), stated that Asian Pacific Islanders historically have had to collaborate in the county in order to receive funding and distribute services. Asian Pacific Islanders comprise sixteen percent of the population of Los Angeles County. Her organization is interested in this project because they bring their expertise in cultural competency, and their INN project, which is focused on the Cambodian community, is already generating interesting data on how to address the issues of disparity and stigma. Because of innovations, they are beginning to understand how necessary integrated care is and how difficult it is to accomplish.

Michelle Winterstein, Ph.D., the Executive Director of For the Child, stated that her organization has been a community-based organization in Long Beach for forty years. They have a comprehensive child and adolescent mental health program with a particular focus on child abuse, neglect, and violence exposure, and offer a broad range of programs. The Kaiser Adverse Child Experiences Study shows that children who are maltreated or exposed to violence often have negative health care outcomes throughout their life span. About eighty-five percent of their clients have had abuse history and are often referred by law enforcement or the Department of Children and Family Services. Her agency serves, primarily, a very low-income community. About seventy percent of families that come to them are Hispanic and eighteen percent are African-American. About a third of the children they serve are uninsured; many are undocumented. Many of those children will not benefit from the ACA. Dr. Winterstein's organization is very committed to providing a safety net for those children.

Patricia Costales, the Executive Director of The Guidance Center, stated that her organization is a mental health agency for children and adolescents. They have some capacity to see adult parents with mental illnesses that interfere with their ability to find and sustain employment. They are a full-scope agency that has been in Long Beach since 1946. Last year, they treated 2,500 children and families and provided more than 76,000 hours of therapy. A significant portion of their services are provided in homes for families that are struggling too much to visit a clinic on a regular basis.

Alan Terwey, the Executive Director of Westside Neighborhood Clinic, stated that his organization has been in operation since 1975. When they learned that MHA Village on Elm Avenue was seeing people with mental health issues, they decided to integrate and wrote a grant for that purpose.

Chair Van Horn asked how MHSOAC can assist in building community-wide collaboration; if the Consortium is developing a model that MHSOAC can help to distribute; how the organizations fit together; if there are pieces missing in their collaboration; and how they have been progressing.

Commissioner Lowenthal stated that Long Beach's police department has both a mental evaluation team, including a clinician, and a quality-of-life team. She asked the Consortium, when the police find people experiencing extreme mental challenges, if they are collaboratively or individually involved with them.

Dr. Pilon stated that the Consortium is very involved with the quality-of life-team. The police prefer to bring people in distress to the Consortium than to prison, but they do not have the capacity to provide any crisis residential services. Due to recent legislation sponsored by Senator Pro Tem Steinberg, they will be receiving funding that they would like to use for that purpose.

Ms. Costales added that they have been cultivating a closer relationship with the police department. One of the issues with children and mental health is that the police will often misinterpret the behavior of a child with mental illness as oppositional or uncooperative. This leads the police to interact negatively with these children. Her agency is gathering clinical experts to offer training to the police department on how to identify mental health or developmental issues in children. They also have the capacity for walk-in emergencies.

Dr. Winterstein added that For the Child provides the child mental health support component to the sexual assault response team in Long Beach. When there has been an acute crime involving a child, that child is linked for mental health services within forty-eight hours of the detective-level interview and forensic medical exam. The abuses are often chronic; there are mental health needs in the families of the children, as well. This team is a good model for a multidisciplinary effort with a mental health component.

Mr. D'Andrea mentioned another model, the city's Multi-Service Center (MSC). While not the direct responsibility of the quality-of-life team, MSC, located about a mile from CVC, serves as an important referral source for shelters, transitional housing programs, and permanent supportive housing. CVC has a good collaboration with MSC, which is itself a collaborative.

Dr. Nicholas added that The Children's Clinic is the medical site at MSC and has medical staff there.

Ms. Kahn stated that PACS, as an example of a response, is using INN funding to care for one of the survivors of a recent shooting, a former client who was treated under the INN plan. He and his family are currently supported as patients through funding from MHSA. Dr. Nicholas added that The Children's Clinic provides the medical care to this family through the INN grant.

Chair Van Horn asked how the panel sees the collaboration taking shape.

Dr. Pilon stated that his impression is that, in these first meetings, the focus is on assessing common goals. The main goal at this time is a shared medical record and information exchange among the agencies. The Children's Clinic and MHALA have already explored that and are about to sign the "organized health care arrangement." This serves as a model for all seven agencies and, in the future, will be helpful in outreach in particular. Care coordination is the key to improved health outcomes and lowered health care cost.

The second broad area the Consortium agreed to approach is shared outcomes. Dr. Pilon believes that outcomes demonstrate a caregiver's philosophy and approach to care. PACS and MHALA both have contracts with INN through LACDMH and are doing different kinds of INN; they have already established outcomes that The Children's Clinic and MHALA are collecting on the mental health side. The Consortium is taking a recovery-oriented approach to outcomes.

Vice Chair Pating asked if MHALA's health affiliation was a workaround for the Health Insurance Portability and Accountability Act (HIPPA), California Law, or 42 CFR (Code of Federal Regulations), and if MHALA is a Qualified Service Organization (QSO). Dr. Pilon stated that he believed it addressed 42 CFR and is a QSO.

Vice Chair Pating clarified that a QSO under 42 CFR allows the sharing of drug abuse information and drug treatment with an organization that provides services to the drug clinic. SAMHSA is promoting this special workaround for the 42 CFR.

Ms. Costales stated that she felt the two goals the Consortium decided to address are obviously linked. It will be an opportunity to measure someone's whole life, not just their mental health.

Dr. Nicholas added that, in addition to the benefits from caring for all aspects of a patient, collaborating on policy and advocacy work and the lack of staffing will promote creative cross-discipline discussion.

Commissioner Lowenthal asked how the Consortium's collaboration fares with language issues and cultural competence.

Dr. Winterstein stated that For the Child has strong language capacity for English and Spanish, but is not strong in Asian Pacific Islander languages; PACS has been a strong partner for many years with respect to language needs. But it goes beyond that, to linkages for families based on needed care. Each organization has its own range of evidence-based practices and different skill sets. If one agency is not the best fit, a family can be linked to another partner based on cultural, language, and geographic needs.

Ms. Kahn pointed out the importance of sharing work forces to avoid duplication of services, because work forces are limited. PACS staff speak a total of ten Asian Pacific Islander languages, but it has taken since 1981 to get there. Currently, they have four full-time clinicians,

one full-time family advocate, three full-time case managers, and three administrative staff members who speak Khmer, the language of Cambodia. The investment in the Cambodian community is a result of the great need in Long Beach, but PACS also responds to other service areas, such as the Hispanic community, which comprises forty percent of PACS clients, and the Filipino community. The other areas where PACS strives to strengthen cultural competency is in the 0-5 population; For the Child, PACS, and a few other agencies in Service Area 8 are linked together under a SAMHSA grant to develop a system of care to improve treatment and modalities for young children.

Dr. Nicholas stated that The Children's Clinic just hired its first Cambodian nurse practitioner, and has Khmer speakers at every clinic site. Almost all of its staff members and most of its physicians are bilingual. They also work with a Cambodian community worker, through the INN grant, who only works with Cambodians with mental illness.

Ms. Costales stated that The Guidance Center staff is sixty-five percent bilingual and bicultural. All children's mental health agencies have seen a tremendous increase in their 0-5 population, which they were not equipped for, so her staff trained to meet those special needs.

Vice Chair Pating asked what brought the Consortium together in the first place, whether the area in which they work or a common problem.

Dr. Pilon stated that all of the agencies were interested in providing better care to the populations they serve. They have the opportunity to explore what degree of integration is the most efficient. Physical health care providers have a completely different way of providing and talking about services than mental health care providers do. To explore where the common language lies is one of the Consortium's goals.

Dr. Nicholas stated that The Children's Clinic had a federal Maternal and Child Health Bureau grant called "The Healthy Tomorrow's Partnership for Children." They brought together the children's mental health care providers in Long Beach and worked closely on sharing resources and increasing efficiency. They did not have enough funding for data collection and sharing or for including adult providers under that grant. This has created the opportunity to care for adults, as well, and to undertake some technical challenges of collaborative agreements.

Ms. Costales stated that there were pre-existing relationships among the seven organizations in the Consortium as they shared and referred clients. She and Dr. Pilon sit on the Steering Committee for LACDMH with regard to Health Care Reform (HCR) planning and have been fully immersed in thinking about integrative care. Dr. Pilon invited her to be a part of a grant application; it fit well with the timing and goals of The Guidance Center.

Mr. D'Andrea added that one of the common denominators is Long Beach. All seven organizations are either based in or have extensive operations in Long Beach, which is a large, but self-contained city. There are deep relationships amongst stakeholders. An argument can be made that all health, wellness, and recovery is local. Being Long Beach bound will be a key driver of the Consortium's success.

Ms. Kahn added that trust binds the Consortium together. The agencies involved have a history of working together. Even though they may have slot allocations depending on language and need, they will take a client a great distance to ensure that that client is not denied services because of language. She stated that several of the organizations are contract providers for LACDMH and understand how it works. It did not seem appropriate, at this time, to partner with them, as the Consortium is currently working at the community-based organization level.

Chair Van Horn asked what the state should be doing to encourage the kinds of activities that the Consortium is involved in.

Dr. Pilon stated that one of the reasons the Consortium has gone this far is because it had outside resources. Foundations have been generous in helping make this process viable. Most localities do not have anything like that. It does not take a lot - the Consortium's grant is for $50,000 to bring seven organizations together to explore these issues.

The issue with HCR is that everyone talks about how important it is to integrate all these services, but there is no guidance, staffing, or resources provided to help people to do that. Everyone is expected to add that on to everything else they are doing. Having the grant and the consultants who provided organization and guidance is an enormous benefit.

Commissioner Aslami-Tamplen asked about the length of time left on the $50,000 grant. Dr. Pilon stated that the grant runs through March of 2014. That does not mean the Consortium cannot apply for additional funding to continue forward, but there is a tight timeline of only six to seven months remaining on the grant. Dr. Nicholas clarified that the plan is what is needed by March. She stated that her assumption that the Consortium will then move to an implementation phase of the grant.

Dr. Winterstein stated that it is important to note that the grant does not pay for the time for those at the table during this process, but it does give the support of structure, consultation, and tools needed to work together. The members of the Consortium are committed to being there and will continue that commitment after the grant ends.

Dr. Winterstein added that fear is also a good motivator. It brings together the child and adult mental health worlds. The functioning of their parents is critical to how children fare in terms of mental health. She felt the fear is the uncertainty around the changing landscape with HCR, which has motivated her to learn what she can from other agencies and people in the community. It is a great time for collaboration to be a benefit, both to the medical and mental health providers and to the other services in the community.

Ms. Kahn stated that the importance of the Commission's understanding that the Consortium is a tremendous effort and under LACDMH, as legal entities, there are many barriers to collaborating and receiving funding. The Commission could look at this in terms of funding for the future.

Ms. Kahn stated that is important to recognize the impact of the INN plan, particularly the Integrated Service Management (ISM) model. The ISM has fourteen ethnic communities represented. The wealth of information the Consortium is starting to collect is important. It is a three-year plan with one extension. She asked that the Commission take a look at the outcomes at the end of the fourth year to determine whether or not the things that they are discovering truly address disparity. They are mandated to provide integrative services that are specific to ethnic communities.

Vice Chair Pating asked whether these kinds of collaborations could be funded under INN. Dr. Nicholas stated that issues have come up in the INN grant related to billing and policy issues. This will be more of an issue when the grant ends. It is important that the Commission know and advocate for issues like this in collaborative grants.

Commissioner Nelson asked what the geographic area of Long Beach is in square miles and what the total population is that the Consortium is looking at. Dr. Nicholas stated that the total population is 465,000, with twenty-two percent below the poverty level. It has a fairly young population. It is the most ethnically diverse city of its size in the country. Commissioner Lowenthal added that Long Beach is 51.44 geographic square miles.

Chair Van Horn stated that the MHS Village chose Long Beach specifically because it was so diverse. It was a microcosm of the U.S.A. in terms of the various population groups. He stated that his understanding that the funding stream is more federal.

Dr. Nicholas stated that in California, there is a “four walls” rule. Medi-Cal and mental health services cannot be done on the same day in the same place, and they cannot be billed together. In order for the provider to be reimbursed, the patient must come back the next day.

Commissioner Lowenthal asked if Dr. Nicholas believed the Legislature could address that. Dr. Nicholas stated that they could and they have brought it forward several times in the past. It is a big issue that has been on the agenda for as long as she has been in the California Primary Care Association (CPCA). Dr. Pilon added it is possible to apply for relief from that requirement, but there are many regulations to overcome.

Commissioner Aslami-Tamplen suggested the inclusion of a consumer-run organization in the Consortium to ensure collaboration with all key partners. To qualify as a consumer-run organization, consumers would need to make up fifty-one percent or more of the organization. Including consumer-run organizations would strengthen the team.

Ms. Kahn recommended that the Commission look at the inability to bill for interpretive services and translation. Organizations are mandated to provide culturally-competent, linguistically-competent services, and yet cannot bill for them. This issue is at the state legislative level. LACDMH has started looking into this and the Commission may want to as well.

Vice Chair Pating stated that there are opportunities under MHSA funding for this kind of activity, either under INN, encouraging counties to provide seed money for the coming together, or under the Capital Facilities and Technological Needs (CFTN) fund. This is what it is supposed to be used for.

One of the barriers for previous INN projects MHSOAC has had is the financial barrier. The issue of Medi-Cal only billing one appointment for one type in one day was a regulatory issue that does not make sense, because people may have more than one problem and need to see multiple providers. A second barrier is related to how licensing occurs in facilities. A federal clinic may not be able to offer certain kinds of services because of the licensing and the different limitations.

Commissioner Buck stated that many providers collaborate around smaller projects - two or three providers working on a grant with a specific population in a specific place. This seems like a larger, higher-level, expanded collaborative. He hoped the Consortium’s consultants, at the end of March, would be able to produce and distribute a written document to help others around California jumpstart. Many of the best actions are inspired not by money but by the right direction.

Dr. Pilon stated that the Nonprofit Sustainability Initiative has hired La Piana Associates to do an outcome study of all of the collaboratives involved. They should be able to produce a report on how these collaborations took place and what the outcomes were.

Dr. Nicholas stated that she has been doing collaboratives for twenty-five years in Long Beach, and echoed Ms. Kahn’s point - it requires trust and knowing each other. Melding different cultures and different organizations to form the Consortium was a long, difficult process. It depends on relationships, trust, shared vision, and mission. The organizations in Long Beach are all serving the same population and need each other in order to care for the community in the way that it deserves.

Chair Van Horn asked if the state has provided any encouragement in terms of its regulatory legislative process. Dr. Pilon stated that they have not asked for any help at this point, but, as Vice Chair Pating pointed out, it is helpful to have someone from the Legislature involved.

Dr. Nicholas stated that there will be policy and advocacy issues that the Consortium would be remiss not to address as a group. The involved organizations work with different advocacy and educational groups, and it would be most effective to bring together adult and pediatric mental health providers.

Chair Van Horn asked if the Consortium's clients live in the housing Mr. D'Andrea's organization provides. Mr. D'Andrea stated that, as the Collaborative begins to share more information, he hoped to report on that. The group that has been convened will be a great springboard, because CVC is in the process of beginning construction on its newest support housing development, called Cabrillo Gateway, with $1.6 million of MHSA capital to make that development feasible.

CVC partners with both MHALA and The Children's Clinic. The Children's Clinic is going to operate a Federally Qualified Health Center (FQHC) on the ground floor. CVC is creating space for them to operate a housing-based satellite clinic. MHALA will be one of their mental health providers for their population. Housing is a convenient, effective setting for this type of collaboration with mental health, physical health, and therapy providers. Mr. D'Andrea hoped the Consortium could begin to document that in a more empirical way and attract more resources to place-based services.

Commissioner Lowenthal agreed that housing is an important component. It is difficult to gather the support of housing projects in other parts of the city. The Consortium's strength will make a difference in the decision-making at the council level. She encouraged the Consortium to consider including an additional housing advocate, perhaps Housing Long Beach or LINC Housing.

Dr. Winterstein stated that some of the agencies have been doing co-located services at the Carmelitos at the Los Angeles County Housing for ten or twelve years. It is a very rich partnership for For the Child. The families that are in subsidized housing have many mental health needs for children and parents. As the Consortium goes forward, they are a partner that would be good to add.

Commissioner Lowenthal stated that this might be helpful in terms of convincing the city and parents that it is already working because it is integrated.

Dr. Winterstein stated that the Los Angeles County Housing Authority also gave them space at no charge to send in mental health providers.

Ms. Costales noted the issue of people who are very marginally housed and are not counted in the numbers of homeless or even at risk of homelessness. However, as an organization that offers home-based mental health services for children and families, The Guidance Center goes to one-bedroom apartments with fourteen or fifteen people living in them. She has visited homes where the front windows have been shot out. The issue is larger than the numbers point out.

Chair Van Horn asked if the Consortium has involved any drug and alcohol programs. Dr. Pilon stated that they have discussed this. There is not a specific substance abuse services provider included in the Consortium. Unfortunately, it is too late to include someone new at this point; however, with the recent changes that the state made to substance abuse Medicaid, some of the agencies may become substance abuse Medicaid providers themselves.

Commissioner Questions and Discussion:

Commissioner Mallel stated that it is exciting that a family can enter into a collaborative method and be able to get a variety of services. If it is not the right fit, they can go to another party that is involved and get what they need. She asked what the Consortium's community outreach is and how families find them. Dr. Nicholas stated that most of it is word of mouth.

Ms. Kahn stated that, under the ISMs, the API-ISMs recently tallied up how much outreach and engagement they needed to do, and each API-ISM is mandated to bring in fifty-four enrolled clients. For the Cambodian, six agencies working together did over 5,000 outreach efforts in order to enroll fifty-four. The Korean ISM did over 3,000 outreach engagements and brought in twenty-four. The Samoan did 3,200 and brought in seven.

Mr. D'Andrea stated that the question was raised about what the Commission and the state can do to help. Several years ago in California, CVC lost $1 billion in redevelopment, which was a wonderful tool to create affordable housing. There is now legislation in Sacramento, Senate Bill (SB) 391, that will replace a piece of that - the California Home and Jobs Act. The Consortium encouraged this Commission to consider support for that important piece of legislation. Chair Van Horn asked someone to mark down SB 391.

Commissioner Brown echoed the commendation to all of the partners of the Consortium in forming this alliance. Yesterday's meeting at MHA Village was an example of breaking down proprietary walls and working with other organizations in everything. This Consortium seems to be a great initiative in terms of getting together as an alliance to further the cause. He encouraged them to not only continue that, but also to bring in the substance abuse element.

Vice Chair Pating recommended three possible outcomes: to speak with Commissioner Lowenthal; to post the Consortium's story on MHSOAC website; and to consider if housing is where the Commission needs to be and if it can foster the integrative housing that Long Beach needs.

Chair Van Horn asked about NIMBY, which stands for "not in my backyard," and how much it affects the Consortium as it looks at service sites.

Dr. Pilon stated that the Consortium just finished a seven-year process where there was substantial NIMBY-ism against a service site resulting from the closure of the Schroeder Hall Military Base in Long Beach. When a military base closes, federal law requires that the first purpose that site be put to is to accommodate homelessness. The Consortium submitted a proposal to provide mental health services to homeless people, and the city council immediately agreed that this was the best way to do this, but then it took approximately seven years from that initial vote to find a site that was acceptable to everyone involved. CVC has the opportunity to welcome and house some of the people the Consortium serves. However, accomplishing community integration for the underserved population will require expanding the entire neighborhood.

Dr. Pilon pointed out that sequestration has not hit his agency directly, but it has hit the amount of housing vouchers available for the individuals they serve. Not only having places to house people, but not having the certificates or subsidies to be able to provide services to them is a big issue.

Ms. Costales stated that The Guidance Center recently consolidated and relocated all its Long Beach locations into one. There is a specific vision of being directly in the community that needed it most. It took three years to find a location, because landlords did not want it. As soon as they learned that The Guidance Center provided mental health services to children, they closed their doors. Ultimately, they found a developer who bought, renovated, and leased a

building on their behalf. The neighborhood is desperate for resources and has embraced The Guidance Center.

Dr. Pilon added that his experience is that city staff is supportive of the mission, but - usually in a small part of a community - residents get up in arms; they are very vocal and it can be scary for elected officials at the city level to support mental health in those cases.

Commissioner Miller-Cole stated that part of the discussion has been around workforce, and he asked if the panel could discuss attracting and retaining the needed workforce. Dr. Nicholas stated that there is a workforce shortage in this area, particularly of Spanish-speaking LCSWs and primary care physicians. Right now, the Consortium has loan repayment for both social workers and physicians through the federal government, but that is at risk because that will be part of the sequestration.

Commissioner Miller-Cole asked about psychologists. Dr. Nicholas stated that they do not have any psychologists, but they also can access loan repayment. That is useful and there are state and federal loan repayments that are extremely important for attracting their workforce.

Dr. Pilon added that the big challenge they are facing is the for-profit health care providers offering more to staff and taking them away. The Consortium cannot compete in terms of the salaries of some of the most in-demand providers. Ms. Kahn echoed that for bilingual staff. The other area where there is a real workforce shortage is child psychiatrists, especially bilingual ones.

Commissioner Aslami-Tamplen stated that, with regards to staffing and the goal of effective outreach and engagement, one of the most in-demand positions is peer positions or family member positions that do the work, in her experience. LCSWs and nurses are important, especially with the integration of primary care, but many of the issues come in with engaging people.

Ms. Costales stated that The Guidance Center does have parent partners. Also, a number of their LCSWs or other therapists are graduates of the children's mental health system or the foster care system. A significant number of their therapists were raised in foster homes and received mental health services; it is possible for mental health providers to be consumers.

Commissioner Buck asked if there is a trickledown theory from this Consortium, if staff are gaining knowledge and working more collaboratively. He recently learned an employee of his agency had never heard of their Crisis Residential Program; information about the services provided must be trickled down to the people who provide the direct support services.

Dr. Nicholson stated that, with community health centers in California, marriage and family therapists (MFTs) cannot be billed for, so that takes out a whole group of the workforce. They also cannot bill if someone with an MSW is getting their hours; conversely, if the same person is at The Guidance Center doing the same thing, they can bill for that, but the community health center cannot. This is a big issue for manpower.

Chair Van Horn asked if that was a federal or a state rule. Dr. Nicholson stated that it was a state rule.

Dr. Nicholson asked if that was because MFTs are not known nationwide. Ms. Kahn stated that that is a congressional issue; they will not allow MFTs to bill under Medicare at the federal level, because it is not a national licensure. Dr. Winterstein stated that it may be the only reality that allows some of the CEOs to still have them on staff.

Dr. Nicholson stated that this Consortium is fairly new, but, through the members' collaborative relationships, they have shared staff and done bidirectional training.

Public Comment:

Mr. Hughes stated that he is thrilled that consumers might be getting medical attention while they are being treated for mental health. In the past that has not been the case. He stated that he is opposed to sharing information between the medical clinics and mental health clinics. He has learned from firsthand experience that a mental health diagnosis written on the medical clinic file makes the patient expendable. Physicians do not take the time - why should they? You are different and no one cares about you. That is the sad reality.

He stated that he hoped for a discussion, as part of the roundtable, on how to keep holistic health and recovery in mental health, which is a core value of MHSA. There is more to holistic health than housing. Mental health issues are spiritual - trauma breaks the spirit. He stated that it is well-known that West African Shamans have better outcomes with schizophrenia than North American psychiatrists have. He suggested those two be integrated where clinics have a West African Shaman.

Mr. Robison thanked the panel and addressed the question of how collaborations and community-based organizations can work together. One of the things that have worked well in Los Angeles County is the learning collaborative with the INN programs, where all four INN programs come together on a regular basis to discuss their progress and outcomes and learn from each other.

It is also important to figure out how to go beyond the community of treatment providers, to focus on the community where people are living. As affordable health care moves forward, the triple aim is lower costs, better outcomes, and better care. Community is the place where people find intimacy, unconditional love, acceptance, support, and connectedness. One of the places where that happens is in self-help support groups, which is why Division 27 of the American Psychological Association (APA) is recommending that self-help support groups with best practices be included in HCR.

One of the things that SHARE does in Los Angeles County with its PEI funding is to maintain a database of 12,000 self-help support groups that deal with over 750 different life issues. No matter what is happening in someone's life, when they are connected with other people who are going through the same thing and who are in their community, they have better outcomes. A robust plan is necessary moving forward to engage with the self-help support groups that already exist in the communities. Another way to do that is with peers. People with lived experience are great connections to the communities. Mr. Robison stated that the voucher-based system for housing is never going to work. There are 1,000 vouchers for 50,000 homeless people in Los Angeles County and a community-based housing program that does not go through a community use permit. They use privately-owned single-family homes and refer and connect people to self-help support groups.

Ms. Lewis-Reid stated that the Long Beach Mental Health Center has a care team that is integrating health and mental health on a limited basis. She congratulated the Consortium on the work they are doing.

Mr. Wilson stated that it is important to collaborate to ensure advocacy so people with lived experience can work with providers to help them understand the other perspective. He suggested having someone oversee the agencies to ensure they connect with each other to make a difference.

Patti LaPlace, the Mental Health Coordinator of the City of Long Beach Multi-Service Center, complimented the work of the Consortium and encouraged them to invite the health department, because they have a strong interest in this area. She thanked everyone for their kind words

about the multi-service center. It is a one-stop-shop model. It is important to have a neutral collocation, because every organization has its culture. One-stop shops, where people can get multiple types of services under one roof, produce positive outcomes, including a sense of accomplishment and the reduction of barriers.

Ms. Innes-Gomberg acknowledged the wonderful presentation and panel. She suggested sharing the lessons learned and information gathered by the Consortium with LACDMH INN program. LACDMH has quarterly learning sessions for the INN program designed to provide learning opportunities. They document the learning through learning briefs; Ms. Innes-Gomberg offered to share those learning briefs with MHSOAC on a frequent basis, if it would help this dialogue.

12. GENERAL PUBLIC COMMENT

Modesta Pulido, a Promotora of LACDMH, representing chair person of Social Justice of St. Philomena Committee, and a National Alliance on Mental Illness (NAMI) instructor from the communities around the South Bay, thanked the Commission for its support and efforts. It has been working tremendously in the inner core of the community, especially in families with mental illness.

Ms. Pulido is a mother of seven children, including three with bipolar disorder and one with epilepsy. She stated that she has seen many needs in the promotoras' implementation. Although only serving in Service Area 7, promotoras come to the community and give presentations on mental illnesses. She also wanted to implement in Catholic churches and other ethnic groups' places of worship. Vice Chair Pating added that the Commission has been supporting the promotoras throughout the state as a best practice.

Mr. Robison stated that his concern about the way consumer- and family-driven participation is occurring. He recommended staying within MHSA guidelines. In Los Angeles County, the Service Area Advisory Committees (SAAC), which were originally fifty percent consumers or family members, have now been changed to two consumer members and two family members. No one knows how this happened; this does not reflect the wellness and recovery mandate of MHSA.

Vice Chair Pating suggested Mr. Robison contact Ms. Innes-Gomberg. The Commission prefers the first level of troubleshooting to occur at the county and board of supervisors' level.

Charles Hughes stated that his appreciation for MHSOAC use of recovery terms; however, the people on the line staff do not know what recovery terms are and are still using medical terms. One of the guiding principles is recovery. The term should be "system of recovery" instead of "system of care." At the county level statewide, it is still "system of care." The line staff, the supervisors, and the department heads have a certain mindset and it comes through. Mr. Hughes stated that he hears reports on their activities, and they are always followed by the same result: "and now they are on medication." Offering food and transport ending in delivery of medication is not holistic.

Nami Roberts, of the Asian Coalition, stated that mental illness is not seen as a first problem for most places, while substance abuse is. Funding for substance abuse is considered more than mental illness. Service Area 8 vouchers have been given to people with felonies, without any type of annual clearance. Ms. Roberts mentioned that one peer had committed suicide, and asked if there is any accountability for oversight done for agencies providing services. She stated that Asian outreach had the lowest utilization rate, as most people are afraid to admit they have - or even to discuss - mental illness. Ms. Roberts requested more outreach and funding for this.

Richard Pulido, the husband of Modesta Pulido, stated that their seven children have mental illness but they are thriving. On behalf of the collaboration of LACDMH with NAMI, he stated that the grassroots efforts that have been working with a strong support system with United Advocates for Children and Families (UACF) have caused a strong faith-based group and a social justice mechanism that is being utilized in the Greater Los Angeles County area.

Mr. Pulido stated that outreach is the key to advocacy and to education for families. He and his wife teach under the leadership of Dr. Paul Stansbury, the president of NAMI South Bay, and Fred Magenhaimer, the president of NAMI Long Beach area. This is the best way to work when creating PEI grants. He suggested expanding on this engagement and the resources for family support groups by implementing the PTA and working to decrease stigma. This is part of what NAMI and LACDMH are collaborating on. Mr. Pulido stated that his belief that SAACs should work with LACDMH as well as with Sheriff Lee Baca in creating local jail systems for youth.

Vice Chair Pating asked when the next NAMIWalk will be. Mr. Pulido stated that it will take place on October 5th at the Third Street Promenade.

Mark Karmatz stated that the Alternatives Conference and the Dove Cassettes websites show that there have been workshops on peer-run crisis support centers. Also, on Monday, there will be a meeting at 600 North Commonwealth in Los Angeles at 1:30 p.m. regarding involuntary treatment. They have been mandated to enforce Laura's Law by the county board of supervisors. Mr. Karmatz is opposed to this; the consumer movement has been concerned about this action, and he encouraged as many people as possible to attend in order to represent all communities for opposition.

Ms. Zinman stated that CAMHPRO, in collaboration with Peers Envisioning and Engaging in Recovery (PEERS), has a contract with MHSOAC for the Client Stakeholder Project. The Commission is modeling what it is going to be studying - best practices in stakeholder involvement.

Ms. Zinman stated that her concern about the scapegoating of people with mental health issues for the violence in this country. She read a prestigious public poll in which support for controlling guns was going down appreciably; on the other hand, blaming mental illness for this violence was going up, which ties in with Mr. Karmatz's comments. Ms. Zinman stated that her concern over the outpatient commitment and the expansion of vehicles for forced treatment that is occurring throughout the state.

Shereeta Garington, a peer advocate, stated that many peer advocates have moved from volunteers to Wellness Outreach Workers (WOW) to community workers. She asked where they can go from there, where they can find answers to their questions, and how they can sustain the jobs. Vice Chair Pating stated that the Commission hopes to roll out $30 million in training and new jobs; this is on the agenda later today.

13. FIRST READ: TRIAGE PERSONNEL GRANT CRITERIA

Commissioner Poaster stated that, since this is a time-sensitive item, he would move to suspend the first read after the presentation, discussion, and public input and proceed immediately.

Executive Director Gauger stated that the triage personnel legislation is known as SB 82. On May 16, 2013, Senator Pro Tem Darrell Steinberg called for state action, which resulted in SB 82, which is now called the Investment in Mental Health Wellness Act. SB 82 authorized the California Health Facilities Financing Authority (CHFFA) and MHSOAC to administer competitive selection processes for capital capacity and program expansion and for specified personnel resources.

In May, the Pro Tem's staff shared the Senator's call for action at a Commission meeting. The Commission endorsed it and sent a letter of support to the Senator. The call for action resulted in this law.

SB 82 states CHFFA will be responsible to add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level, in order to improve access to mental health crisis services and address unmet mental health care needs. The bill also states that the Commission will be responsible to add at least 600 triage personnel, to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access in the community at places such as homeless shelters, jails, and clinics.

Through SB 82, the Commission was given a description of what services the triage personnel may provide and some criteria for selecting the grant participants. The law provides some guidance for developing the criteria for possible services the triage personnel may provide. For example, they may provide targeted case management services face-to-face, by telephone, or by telehealth; they may provide communication, coordination, and referral; they may monitor service delivery to ensure the individual accesses and receives services; and they may monitor the individual's progress and provide placement service assistance and service plan development.

The bill also included some grant criteria. It suggests that the applicant provide a description of the need, including potential gaps in local service connections; a description of the funding request, including personnel and the use of peer support; a description of how triage personnel will be used to facilitate linkage in access to services; and the ability to obtain federal Medicaid reimbursement if applicable.

The bill also stated that geographic areas or regions of the state to be eligible for grant awards shall include rural, suburban, and urban areas, and may include the use of five regional designations that are currently used by CMHDA.

Commission staff recruited experts from various fields related to this project to create a Subject Matter Expert (SME) Work Group. The work group advised and provided TA to staff in development of the criteria. From information in the law, staff created a premise paper and an issue paper and provided these documents to the SME Work Group, which met on August 22nd and September 5th, 2013.

The premise paper contained information that staff believed would be critical to include in the Request for Application (RFA). The issue paper, the most important part of the process, identified a number of issues that required input from experts in the community.

In regard to grant criteria, the law states that applicants are limited to counties, counties acting jointly, or city mental health departments. If counties are acting jointly, the applicant county must identify in its application all counties it will collaborate with.

In regard to funding, $32 million in MHSA funds will be made available annually to fund triage personnel grants. It is anticipated that the overall funding for triage personnel will include some amount of federal Medicaid reimbursement when the service being provided is Medi-Cal eligible. The law also states there are no matching funds required from counties.

Staff recommends three-year grants, with funds being allocated annually, and reporting requirements throughout the three years. The grant apportionment will be based on CMHDA's current five regions and DHCS 2013-2014 MHSA formula distribution, which has been in place for quite some time. Counties will compete within their own regions for grant funds. Staff felt that apportioning in this way ensured that urban, suburban, and rural counties will receive some of

the funding. MHSA formula contains criteria within it, such as county population, county uninsured population, state resource allocation, and the county cost for self-sufficiency. These are already factored into MHSA distribution formula.

Deputy Executive Director Hoffman stated that, for program narrative, the applicant should provide a description of current crisis response systems and needs, including where triage staff are needed to fill gaps and link to appropriate services, the number of triage personnel required by type of position, and any racial, ethnic, and cultural groups targeted for services.

For collaboration, the applicant should provide a description of local efforts to coordinate and collaborate with partners, including counties and law enforcement, local social networks, hospitals, mental health and substance use non-profits, and foundations and providers of services to racial, ethnic, and cultural groups, including low-to-moderate income people.

For program operation, the applicant must provide a description of the program operations and activities to be performed by triage case management staff, including communication, coordination, and referral, monitoring service delivery, monitoring an individual's progress, and providing placement services assistance. The grant applicant must describe how triage staff will be deployed, whether they will be field-based or mobile, if triage case management staff includes persons with lived experience, and if the county intends to use contract providers.

For local evaluation, the applicant will provide a description of how they will evaluate the effectiveness of increased triage personnel, goals, and the outcomes to be tracked.

For reporting and evaluation, the grantees will be expected to report on the number of triage personnel hired or contracted, the service locations, and the points of access, such as emergency rooms, shelters, and jails. Also, they will be required to report this information at six months and twelve months after the grant award. The grantees must provide information on total unduplicated persons served, total number of service contracts, basic demographic information for each individual served, and services that individual was referred to by triage personnel. This information will be required at the end of the first year, and every six months throughout the grant cycle.

As a next step, staff will write the RFA upon approval of the criteria from the Commission. The proposed date for release of the RFA is October 3rd, 2013. MHSOAC has calculated sixty-five days in the timeline for the counties to complete their applications. The Commission is scheduled to meet and approve the recommended awards at the January 2014 Commission meeting.

Commissioner Questions:

Vice Chair Pating asked if there is a staffing service component of CHFFA grant. Executive Director Gauger stated that they have the ability to staff the mobile crisis response teams that will be going out and also to do the construction and renovation grants. CHFFA has a personnel piece, as does the Commission.

Chair Van Horn stated that it is only a one-time fund. They will need to figure out how to finance a crisis program later. The only repeating funding is the triage system. The capital grants are about $53,000 a unit, which is hardly enough for construction.

Commissioner Miller-Cole asked for background on the grant regarding the county's intent to use contract providers, county staff, or both. Deputy Executive Director Hoffman stated that the law did not say how they must do it; it only said that they had the opportunity to contract out, use county staff, or do whatever is necessary in their county to meet their needs.

Executive Director Gauger added that staff wanted to include this after gathering input from the subject matter expert group. In some cases, it is easier to contract with providers, so staff wanted to have both options in the criteria.

Vice Chair Pating asked if there was an evaluations requirement or component to this. Deputy Executive Director Hoffman stated that the counties will determine how they will evaluate the triage program, so it will go through local evaluation.

Public Comment:

Mr. Hughes stated that he has questions and concerns about hiring and performing the triage, such as who initiates the triage and who makes decisions.

Ms. Hanna stated that her concern that, while peers are mentioned, there is no language about indigenous helpers.

Mr. Kingdon commended the Executive Director and staff for their helpful and efficient use of the stakeholder input group. CMHDA was a part of that; it was very well used - a model for others.

Ms. Lewis-Reid asked the Commission to consider requiring a percentage of the 600 workers statewide to be persons with lived experience, rather than the counties making that decision. Also, as referrals are made for triage away from the initial point of crisis intervention into the system, she had concerns over who will make those decisions and whether they will consider the counties of clients in their decision to place them. SB 585 has just been signed by the governor and will bring Laura's Law money into the situation; it is supposed to be voluntary, but she felt more referrals may head that way because the money is available.

Marissa Squirrel Celeste stated that she is a former WOW with Long Beach Mental Health. She stated that her concern over the limitation in having the peers that are part of this program unable to go out in the field without staff support, when the purpose of having peers in the system is for them to be able to do things in the field that staff are unable to do.

Pamela Inaba, the Chair of the Los Angeles County Client Coalition, a mental health client-run advocacy group, stated that consumer professionals who have lived experience have a unique perspective of the professional background, education, and experience, combined with the lived experience of being a client.

Ms. Innes-Gomberg asked if counties are required to have a stakeholder process prior to submitting their applications. Executive Director Gauger stated that it is not a requirement of the law. The law encourages counties to reach out to hospitals, law enforcement, and communities as they develop their applications.

Commissioner Discussion:

Commissioner Poaster commended staff for their accomplishments under pressure. He stated that his concern over the lack of connection between the crisis function and the triage function. Executive Director Gauger stated that staff has been meeting with CHFFA staff on a regular basis. They are new to the mental health system, so MHSOAC staff are providing them with information and sharing the Commission's criteria and process.

Commissioner Poaster stated that he had been confused over the terms "triage worker," "crisis triage worker," and "mobile crisis teams," but acknowledged that there has been coordination and it sounds better now. He asked what their timelines are.

Executive Director Gauger stated that the Commission's report to the Legislature is due March 1st, while CHFFA's report is not due until May.

Vice Chair Pating asked Mr. Kingdon to elaborate on coordination around crisis units. Mr. Kingdon stated that Executive Director Gauger has done an excellent job coordinating with CHFFA. There will be an alignment. The issue is that it will take a while for the "bricks and mortar" to happen, and this has to happen before that. But, as has been stated that, the intent of this funding is that it is ongoing, but it will probably be a few years.

Vice Chair Pating stated that there was talk at one point about these triage roles having a strong peer underpinning relating to the triage functions. He noted in the job descriptions a range that could include physicians in triage roles.

Mr. Kingdon stated that the author did a great job of creating a priority for persons with lived experience. In this state, there is a leadership group that has been working on peer certification for quite a while. He assumed the nexus will be between that peer certification process and the ability of counties to move ahead with hiring persons with lived experience in the field.

Vice Chair Pating asked if Mr. Kingdon had a sense of where the skill set and the alignment with crisis services might end up. Mr. Kingdon commended staff again for making sure this was a user-friendly process. It took a lot of input. He believed the small counties will not be disadvantaged in this circumstance. As a matter of fact, as it is written, many small counties that do not have coverage will be able to build that through this. In answer to Vice Chair Pating's question, he clarified that CMHDA is endorsing this.

Commissioner Brown stated that he has one proposed addition to page 3 of the draft overview. Among the specific objectives, in number two, conspicuously absent from that are jails. Jails are an important element because of the number of mentally ill people in jails. A discharge-planning element to triage to help people receive treatment and services at the time they are discharged from jail is especially important. Executive Director Gauger stated that staff will add that.

Commissioner Aslami-Tamplen asked Commissioner Brown to clarify if there was any triage inside the jails. Commissioner Brown stated that clients are normally triaged when they come into jail to get mental health services in jail. The issue is when they are being discharged, trying to make the connection to get them new or continue existing services once they are going back out into the community.

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

MHSOAC waives the Commission's Rules of Procedures, Second Read rule, for the proposed criteria to be used in the Triage Request for Application.

- Motion carried, 11-0

Action: Commissioner Lowenthal made a motion, seconded by Commissioner Buck that:

MHSOAC approves the proposed criteria to be used in the Triage Request for Application, including the revision to Objective 2 on page 3 of the Draft Triage Personnel Grant Criteria to include a jail discharge-planning element.

- Motion carried, 11-0

14. FINAL REPORT FROM 2013 MHSOAC COMMUNITY FORUMS

Chair Van Horn stated that the community forums have been a joint effort of the Client and Family Leadership Committee and the Cultural and Linguistic Competence Committee.

Commissioner Nelson stated that the community forums included in this report are for San Luis Obispo, San Bernardino, Sonoma, and Monterey Counties. Approximately 1,500 people joined

in the forums since they started in 2010. In the past year, approximately 600 people participated.

Several findings or themes emerged from the forums during the past year. Positive feedback indicated that peer services were effective and clients would better identify with peer providers. In addition, counties have started local anti-stigma campaigns, now have persons with lived experience on staff, utilize PEI programs in local schools, and have increased outreach for suicide prevention, all contributing to stigma reduction.

Counties also have increased bilingual mental health services, utilized mental health services in schools, started a mental health court, and have given parents mental health education.

Challenges voiced were the need for cultural competence, better coordination of services for people with inadequate private insurance, more timely access to services, and assistance with transportation to various appointments and support groups.

It was also revealed that there was a need for improvement and expansion of services, including more mental health professionals, in order to meet service demand, expansion of housing programs, and more TAY services and programs.

A significant number of participants had not heard of MHSA, and indicated a need for education about available mental health services and their funding sources, and the need for supported education and employment.

The issue resolution process (IRP) remains a challenge. The Community Forum Workgroup members and staff need to develop a standard procedure to give uniform and consistent advice to community forum participants who are not satisfied with their services.

Commissioner Nelson provided three recommendations to the Commission:

- The Commission should direct staff to share information about positive impacts and service challenges identified at MHSA Community Forums directly with county mental health departments.
- The Commission should request an update from DHCS on the status of the $400 million MHSA housing program.
- The Findings of this report will be shared with the Evaluation Unit to determine the feasibility of using the findings for possible future evaluations.

Public Comment:

Beatrice Lee, the Executive Director at Community Health for Asian Americans and President of REMHDCO, stated that she is pleased to hear about these forums. MHSOAC is interested in hearing from communities. She wished that these forums could be more sensible to the communities. She suggested involving the counties in the forums, because they have their MHSA stakeholders and culturally-responsive groups, which would allow the local people to attend the forums. She stated that she was not surprised to see the concern about cultural competence and would like to see how the Commission will address that issue.

Ms. Lee referenced page 5 of the report about service challenges to increase access to services for those that need bilingual services. She suggested that the Commission consider gathering data on the percentage of organizations that serve populations from underserved communities in comparison to the entire range of providers. Such data will illustrate that an increase in cultural competence and access to services would allow the Commission to pay more attention to small ethnic-based organizations.

Ms. Hiramoto stated that these forums are an excellent way to inform the community about MHSOAC and MHSA. REMHDCO hears about many community organizations that serve populations who have not heard of Proposition 63 or MHSA. Although she was on the Cultural and Linguistic Competence Committee, which had many concerns about the forums, Ms. Hiramoto hoped the forums and other outreach efforts would continue so that underserved racial, ethnic, and cultural communities can learn about MHSOAC and Proposition 63. She cautioned against relying on the forums to ascertain the needs of racial, ethnic, and cultural communities.

Commissioner Lowenthal asked if it would be possible to live stream or video the forums to make them available to people statewide, either for the future or for people who cannot travel to the extent necessary to attend the forums.

Chair Van Horn stated that the Commission has been encouraging these community forums; there have been nine so far. They started out very small, and then they started engaging counties in the area to assist in letting people know. Participation increased to as high as 250 attendees. He felt the forums are a much better input process than a one-to-three-minute comment window at a Commission meeting.

Executive Director Gauger stated that, regarding recording input at the community forums, stakeholders felt that maintaining their confidentiality was important. Live streaming might lose the ability for stakeholders to maintain confidentiality.

Commissioner Aslami-Tamplen added that the beauty of the forums is in the breakout sessions, where about six different groups evolve. It would be difficult to live stream that. It is a wonderful event with a mass of information shared between a variety of people.

Commissioner Nelson stated that there is the possibility that the Commission could take a video of the presentation, which is basically an information item about the forum but also talks about Proposition 63 and MHSA.

Vice Chair Pating thanked Commissioners Nelson and Mallel for attending and representing the Commission at the forums. He noted that the findings include the issue resolution process, but it is not part of the motion.

Commissioner Nelson stated that the slideshow recommends first going to the local level, and then to the state. He was unsure if DHCS has an effective resolution process in place. Also, different people approach different members and staff at the forums. He recommended having a procedure that everyone can use to receive the same information. He is looking at some education for the community forum members and staff that attend the forums.

Action: Commissioner Nelson made a motion that:

MHSOAC adopts the recommendations in the 2012-13 MHSA Community Forums Report.

- Motion carried, 11-0

15. PRESENTATION ON EMPLOYMENT OPPORTUNITIES FOR PEOPLE WITH LIVED EXPERIENCE IN THE COMMUNITY MENTAL HEALTH SYSTEM

Presenters:

Michael Wimberly, Manager of the Healthcare Reform Team of the Office of Statewide Health Planning and Development

Katherine Ferry, NAMI CA and Working Well Together Governing Board Member

Debbie Van Dunk, of UACF, and Technical Assistance Center Coordinator

Sharon Kuehn, Social Inclusion Manager of PEERS

Michael Wimberly

Michael Wimberly stated that he oversees the Workforce, Education, and Training (WET) program. MHSA WET, which is a five-year plan, was transferred from the Department of Mental Health to the Office of Statewide Health Planning and Development (OSHPD) in January. Between January and now, there has been a lot of work on developing the five-year plan. In 2008, a previous five-year plan was developed, and it set a foundation and established many programs. OSHPD's charge as it relates to the five-year plan is simply this: what next? What have we done that has worked well? And what can we do now?

The focus of WET, the Health Care Research Training (HCRT), and the Healthcare Workforce Development Division (HWDD) are closely aligned. Mr. Wimberly stated that OSHPD WET five-year plan is for 2014-2019. With the elimination of the DMH in July 2012, MHSA WET programs were transferred to OSHPD. OSHPD is accountable for the development of the next five-year plan.

The five-year plan will provide vision, values, mission, measureable goals, and objectives. OSHPD embraces outcomes and measurements, and has secured an outside contractor to learn how the measurements can be determined and captured. Next, a baseline will need to be established, especially with implementation of the ACA. OSHPD will benchmark successful strategies and adjust less successful ones.

OSHPD will have proposed actions, strategies, funding principles, and performance indicators for the use of the remaining MHSA WET funds. It will be accompanied by a five-year budget that will allocate the remainder of the funds and allow the opportunity to provide changes. The five-year plan requires final approval by the California Mental Health Planning Council (CMHPC) by April 2014.

OSHPD's five-year plan incorporates elements that are in statute and are similar to the previous five-year plan. They looked at the statute, the programs, and measures that went well, and considered what could be done better next time. Although there is guidance in statute, it does not necessarily dig down into the significant details of who and how. OSHPD is looking closely at answering those questions.

OSHPD developed the five-year plan with the feedback of fourteen focus groups, community forums, two surveys garnering 6,000 responses, and one-on-one interviews in an extensive stakeholder engagement process. They identified trends and looked at each objective, each goal, and specific action items. There are many ways to do outreach, and OSHPD is trying to find the best way.

Additionally, to provide an opportunity to look at the plan in detail, they convened two Committees, WET Advisory Committee and WET Five-Year Subcommittee. OSHPD presented the first draft of the five-year plan to the subcommittee last week. They did small breakout groups to discover what they did right and what they needed to change; the feedback they received showed they were generally on the right path.

That feedback will help finalize the first draft. Then, OSHPD will go out to stakeholders again to get their input on the first draft of the five-year plan. They will not do the fourteen forums all over California again, but they will hold webinars and open comment periods for feedback.

Some of the recommendations from the stakeholder engagement process are standardizing core competencies, clear job duties and descriptions, certification, reimbursement, training and internships, integration with provider team supervision, livable wages, and upward mobility.

AB 110 gives one-time funding for items like the consumer and family member Request for Proposal (RFP). It "mandates that funds appropriated for peer support, including families, training in crisis management, suicide prevention, recovery planning, targeted case management assistance, and other related peer training and support functions to facilitate the deployment of peer personnel as an effective and necessary service to clients and family members, and as triage in targeted case management personnel."

Mr. Wimberly stated that WET five-year plan includes a subcommittee for career pathways, one of which is peer support specialists. They sent a survey to the stakeholder group in August, and held a focus group on September 12th to further clarify how to write the RFP. They are currently in the process of analyzing that information.

The feedback they received from the surveys, the community forums, and the career pathways aligns. The survey included questions on the subjects peer personnel should learn to prepare them to fulfill their roles, how those roles span the health care system, how jobs should be developed, and what type of training was the most effective, such as on-the-job training. According to the survey, the roles best suited for peer personnel include case managers, recovery coaches, and administrative workers.

Commissioner Questions:

Vice Chair Pating referenced page 7 of the PowerPoint presentation, noting that, "historically underfunded, the Public Mental Health System (PMHS) suffers from a shortage of mental health providers in addition to mal-distribution." He asked if this was the department's official position. Mr. Wimberly stated that one of the driving factors of the Healthcare Workforce Development Division (HWDD) is looking at rural, underfunded, and underserved areas, because they recognize the lack of providers.

Vice Chair Pating referenced page 10 of the PowerPoint presentation, the statewide technical assistance center's (TAC) ten-year expenditures, asking what part of technical systems would be overlapped. Mr. Wimberly answered that the major TA is in the form of Working Well Together (WWT). They have had deliverables in the contract for a number of years. OSHPD is working on their final deliverable from WWT to gather all those measurements.

Vice Chair Pating stated that, regarding the amount of money that has been spent - $400 million over ten years - one of the frustrations is the absence of outcomes data on how many jobs have been created, what types of trainings were provided, and how much progress was made towards meeting the mental health shortage. It has been hard to quantify. He asked if there were any numbers other than financial allocation data.

Mr. Wimberly stated that it depends on profession. There are numbers about added positions and population size, but there are no numbers specifically regarding peers. When OSHPD submits the RFP and develops the plan, they intend to have measurable goals. OSHPD is focused on measurable outcomes going forward.

Chair Van Horn asked Mr. Wimberly to forward the presentation OSHPD will give at the CMHPC's October 18th meeting to MHSOAC staff.

<u>Katherine Ferry</u>

Katherine Ferry, of NAMI CA and a WWT Governing Board Member, stated that she is relatively new to the WWT collaborative. WWT is a workforce development project for peers with lived

experience who are employees or volunteers in the public mental health workforce. The project provides education and support. “Peer” includes people living with mental health conditions as well as family members, parents, and caregivers. WWT is a collaborative partnership of four organizations: NAMI CA, UACF, California Institute for Mental Health (CiMH), and CAMHPRO-PEERS. Each of these organizations provides TA to a different California region, and collaborates to provide TA to the Los Angeles region.

The WWT Mission: “Working Well Together Training and Technical Assistance Center (WWT TAC) improves county public mental health agencies’ ability to assess the readiness to initiate or expand the consumer, family member, and parent/caregiver workforce. WWT TA Coordinators, of which each organization has one, in addition to their governing board members, the Coordinators offer training and TA services to county mental health agencies to ensure they can strategically plan to recruit, hire, train, support, and retain a multicultural consumer, family member, and parent/caregiver workforce.”

One of the major WWT 2013-2014 deliverables is for WWT’s partner organizations to provide TA visits to individual counties. During the TA visits, mental health directors; MHSA or WET coordinators; peer employees; consumer, family member, or parent/caregiver employees; human resources representatives; representatives from wellness centers; and county-contracted agencies are invited. Throughout the six years of their contract, WWT provided 288 TA site visits to 58 counties.

Another deliverable is the provision of a variety of types of statewide trainings - regional trainings, webinars, e-learning curricula. The topics included in trainings focus on interacting with leadership, individual and family wellness plans, and outreach to multicultural populations. WWT also delivers a statewide website, targeting peer employment in public mental health agencies.

WWT provides workforce development tools, such as WWT consumer and family member employment development assessment tools, and the WWT recruitment and retention guidelines are both used in county TA visits. Both are available on the WWT website. The WWT white paper, “Four Key Elements to Successfully Employ People with Lived Experience - as Consumers, Youth, Family Members, Parents, and Caregivers - within Public Mental Health,” is pending release.

Deborah Van Dunk

Deborah Van Dunk, of UACF, WWT TAC Coordinator for the Greater Bay Area region, stated that her main priority is WWT, and she has been in her position for four years. She introduced the WWT website. It includes contact information, a calendar of events, a quarterly newsletter, partner trainings, degree and internship programs, a job board, job descriptions for peers and consumers, and a list of trainers and consultants. The website also contains several employment tools, such as an assessment tool and guideline checklists used for site visits, which gets providers in touch to prepare to hire consumers and family members. Additional resources include the statewide networking all - a monthly peer or family networking call, 45 to 50 minutes long, pertaining to workforce and education. Other curricula, trainings, and e-learnings are hosted by the CiMH website.

In the last six years, the TA Coordinators have achieved increased networking, empowerment, and leadership; promoted dialogue and strategies for Wellness at Work; moved peer employees beyond entry-level positions; held regional trainings of licensed staff to support lived experience in the workforce; improved job descriptions, orientation and supervision for hiring, training, and retention; and increased planning for professional development.

WWT ongoing deliverables for 2013-2014 include TA for individual counties; two statewide training and educational resources; regional trainings, webinars, and e-learning; the website; continued statewide networking calls; a toolkit of models being used in other states for hiring consumers and family members; product marketing and dissemination; and the survey analysis of employee challenges and solutions.

Sharon Kuehn

Sharon Kuehn, representing CAMHPRO-PEERS, the Social Inclusion Manager of PEERS, noted that the interest in working toward statewide certification for peer specialists is not new. The DMH and other organizations have had meetings even before MHSA to discuss the possibility of using Medi-Cal as a reimbursement method for peer support services.

In 2010 and 2011, the California Network of Mental Health Clients (CNMHC) formed a group called the Peer Support Coalition to look at what other states had done around certifying peer specialists and writing state plan amendments to carve out the purpose of peer support services. WWT, in the last three years, has had projects around the idea of peer certification.

WWT has completed three deliverables around peer certification. Initially, the CNMHC had contracted with Inspired at Work, who did a number of projects with WWT, including looking at research from other states. The employment of peer specialists not only increases recovery outcomes and recovery focus, but diversifies the workforce and saves money. They initially began a stakeholder process and, in 2012, WWT published the summary of regional stakeholder meeting findings. Then, last year, after the process that involved consumers, family members, and providers in five meetings across the state, Inspired at Work compiled the result. They held a statewide summit in Sacramento last May. Out of the vetting process came the draft of stakeholder recommendations from California.

The impetus behind achieving peer certification in California is to expand the peer workforce in order to offer more services at lower costs and have higher recovery outcomes. Fourteen other states already have peer-certified partners. Accomplishing this in California is a challenge. WWT proposes not only a consumer certification, but adult, youth, older adult, family member, and parent/partner certification. They want to legitimize the profession by being clear about standards for skill sets, understanding how to facilitate self-determination, and approaching without pathologizing.

WWT understands the need to bring costs down and bring positive outcomes up in order to achieve their goals. Ms. Kuehn stated that the question is, since the challenges in California are big, spread-out, and diverse, how to honor different groups while maintaining a centralized standard. The proposal, based on recommendations in answer to this question, is to create a certifying body. This model has been used in a few states where one government entity or community-based organization has enough authority to be the body that will maintain the standards, grant the certification, and track the continuing education units for recertification, which is proposed to occur every three years.

WWT recommends eighty hours of standardized curriculum and an exam. Included in the preparation process is a six-month internship process incorporating both classroom training and on-the-job experience.

Commissioner Questions and Discussion:

Commissioner Aslami-Tamplen asked how the Commission can provide help and support to move the peer specialist certification forward quickly.

Ms. Kuehn asked the Commission to look at OSHPD's five-year plan draft. They have named consumer and family members in the plan and there is room to give feedback and make specific

recommendations. OSHPD will be making their presentation to CMHPC, so this will let CMHPC know that peer certification should be prioritized. There is a timing factor with the ACA coming.

Chair Van Horn stated that his concern that peer employment will become the bottom rung of the career ladder. He asked if it would be more like moving up a career lattice.

Ms. Kuehn stated that, in addition to the concern about ensuring there is consumer and family leadership, defining the language and values and who will make the final decision is an issue. WWT prepared an example of a peer specialist career ladder and one of the recommendations was to roll out training for staff to understand the role of peer specialists so they welcome them and do not create situations where people are being set up for failure. It is a situation with a great risk, but also a great reward.

Chair Van Horn asked if OSHPD is prepared in this process to budget dollars within the five-year plan to ensure that this happens.

Mr. Wimberly stated that the budget is not the ultimate decision of OSHPD, but they can offer recommendations for CMHPC to approve. There were reasons OSHPD developed career pathways, and one of them was peer support specialists. It is also telling that OSHPD has continually surveyed the peer community. As it relates to specific dollars, there are questions about a certifying board, the curriculum, and county needs.

Commissioner Nelson stated that OSHPD received a budget trailer bill of about $2 million. He asked what that was intended for, including peer certification. Mr. Wimberly stated that it depends on how “employment of peer personnel” is interpreted. OSHPD is working hard to have the proposal equitably distributed and to tie it to positions in public mental health - and not just strictly entry-level positions.

Ms. Kuehn added that, when they first found out about that bill, they hoped that it added funds for the specialization of crisis services, because the plan they recommended had eighty hours of training for a basic peer specialist, and then another twenty-five hours or more for particular specialties. If the timing had lined up, it would have been perfect to have funding for peer special certification, and then additional funds for the immediate focus on crisis services. Instead, there will be $2 million for crisis peer specialists, going through one agency. The ideal for whole state would be to have a certifying body to fine-tune trainings to meet standards, but also to have certification happening around the state, honoring the locally-developed trainings.

Commissioner Nelson asked if there is a suggested chronology for the seventeen recommendations. Ms. Kuehn stated that WWT could make it chronological. There are multiple things that must happen in a similar time frame. There are deliverables going forward this year that entail the CiMH taking the lead on calling together three meetings that will involve OSHPD working together with CMHDA and DHCS. Having these groups come together will be important for some of the big decisions that need to be made, such as what the appropriate certifying body is, and then creating some designations for the leadership for this process. People must have assigned, paid-for time to do this, because it will be a lot of work.

Commissioner Buck stated that smaller employers want applicants with a greater skill set, or as much of a skill set as is possible to perform the job. Those who are in mental health and believe in hiring people with lived experience also want applicants to come with as good a skill set as possible. He strongly supported this effort, however, there are other issues that must be recognized and worked on, such as poverty issues, criminal records because of untreated psychiatric disability, and so on.

Commissioner Mallel asked if the licensure could go through the state. Ms. Kuehn stated that there is a capacity issue, and, because the aim is for a multilevel consumer and family member

certification, they have to address the fact that they cannot give it to a consumer entity for the family groups. They need to continue collaborating so that everyone feels represented.

Executive Director Gauger asked how this is different from the certification provided for substance abuse counselors. Ms. Kuehn stated that it is similar. Eventually, WET will do co-occurring joint certifications, but, for now, they have substance use. They also had a career pathway process with OSHPD; they have four or five different certifications in the state. When one group presented, the members of the other certifying groups were feeling left out. She stated that she would like to see a process where they learn from their experiences and establish one central, certifying body that honors the huge territory and different groups in the state.

Chair Van Horn stated that this is less a clinical certifying body and more a social model body. He stated that WWT is on target, looking to identify one body that certifies or sets the standard for certification across the subpopulations. It is critical, if they are to remain true to MHSA values, to have that variety.

Public Comment:

Mr. Robison suggested including training in best practices for both referrals to self-help support groups, and for starting self-help support groups in the draft. Part of the role of a peer specialist is to connect people to other peer specialists so support connections are available to people around the clock.

Mr. Gilmer challenged the presenters and the Commission to expand the net. He stated that his support of peer, family member, and consumer involvement and would like to see the matriculation upward for job creation and stability, particularly because of the connections to many underserved families, children, and adults throughout the state. When he looks through the lenses of racial, ethnic, and cultural communities, he finds it difficult to see his community embedded in this proposal. The terminology and how it is articulated in the initiative is very different from the terminology used in cultural communities. It would be more appropriate to expand the net to include cultural terminology, because some people do not identify with the terms and idioms that are used. He emphasized the importance of creating a pipeline so that representatives from communities can be stable as paraprofessionals and also move into higher levels of the system. This initiative is wonderful - the engine that can bring about systems transformation - but it needs to be culturally congruent.

Beatrice Lee stated that she recognizes the valuable work of paraprofessionals and supports legitimizing this category of the workforce. Ms. Lee suggested the certificate program be called something other than peer support, such as community advocate support or, as suggested earlier today, indigenous helpers. These are examples of language that would not limit the certificate program to building mental health experience. She also suggested the definition of lived experience for certification be expanded to include cultural competence. Ms. Lee stated that she would like to see a recommendation that builds capacity for the system to serve underserved communities.

Angel Galvez, an administrative specialist with the DMH in Tulare County, stated that peers incorporate many diverse groups. It is a lived experience component that brings this diverse culture into the game. Tulare County is a rural county and is separated by agriculture and dairies. It has many unserved and underserved communities that have these types of individuals. He stated that his support for this effort, provided, as funding is developed and allocated to this effort, rural and small counties are incorporated into the plan.

Richard Krzyzanowski, a member of the Client and Family Leadership Committee and Regional Partner in MHSOAC stakeholder project, stated that, four years before MHSA passed, he took

his first mental health professional position in the same clinic where, for the past three years, he had been receiving services. He knows what it is like to have the perspective of an individual who, because it is new and experimental, bears the burdens of systemic issues. He wanted to introduce that perspective to this conversation. As important as cultivating and preparing the individuals who are bravely walking through these doors is, supports must be given to the systems and the intelligent management and oversight that they need.

Regarding the issue of retention, people with lived experience are often brought in to the profession and quickly put in a “last hired, first fired” situation as soon as difficulty arises. He asked that people with lived experience no longer be used as a political mechanism to acquire funding.

Regarding career mobility, there are many entry-level, low-paid peer ghettos within the profession. He asked that people be given opportunities to grow professionally beyond the peer level or peer designation.

There are peers with lived experience integrated throughout the mental health profession from the top down already; however, many of them will not disclose their lived experience because of the very stigma that is unique to the profession. It impacts opportunities for individuals and negatively impacts the integrity of the profession.

Raja Mitri, a member of the California MHSA Multi-Cultural Coalition (CMMC), highlighted the need for cultural awareness and linguistic competence for effectiveness by peers to involve stakeholders from cultural communities and deliver culturally-competent services of excellence. This core value, which cuts across all practice areas, is essential in developing leadership and building management positions among peer specialists and peer providers. In the recommendations, he was pleased to see reference to using people with lived experiences. He stated that his belief that this description of people who have lived experience broadens the avenue to reach individuals from underserved cultural communities without attachment of stigmatizing labels. He asked that the Commission ensure the landscape of social justice viewed through a cultural lens will constantly guide them in their recommendations and decisions, and the recommendations of certification of peer providers.

Steve Leoni, a consumer and advocate, stated that peer services have been around for decades. They began with people in hospitals, when hospitals had service models and advice that is no longer endorsed by the profession. In defense of themselves and to get some kind of help, the people helped each other. When they left the hospitals, they maintained their connections. This is the origin of what has been called self-help. In a way, this certification is a means of protecting that unique history, because, in many cases, people working as “peers” in organizations are made to function in a traditional manner. The nature of peers and peer services is not just about the origins of competence; it is about relationships. Peer certification is a way to walk that tightrope, because it is a contradiction in terms - both people are peers and equals, but one person is being paid and the other is not. To be able to navigate that in a different kind of relationship requires a different kind of certification or background rather than being forced into being just one more guild. Peers should be the cutting edge of changing the system.

Viviana Criado, member of CMMC and Executive Director of the California Elder Mental Health and Aging Coalition (CEMHAC), congratulated WWT for the work they are putting together, and the Commission for giving it the time to start building the support this initiative deserves. She stated that she is pleased to see that a Senior Peer Certificate will be part of the program.

Senior peer counseling programs and certificates have been around for many years. Throughout the years, these programs have filled a gap in care. The classes usually take fifty or

more hours and a component that allows them to have practice. Having weeks in between allows them to build competency. They are certified only after they are able to demonstrate competency.

Ms. Criado noted only fifty percent county participation in this effort. She strongly suggested looking at rural and multi-cultural communities. She stressed the importance of engaging not only seniors who are doing the job, but clinical supervisors who support this group of paraprofessionals.

Raul Villarreal thanked the Commission for the great work it does. He stated that he just finished a fifty-four hour, six-week peer advocate training sponsored through LACDMH. He stated that his disappointment at the minimum amount of teaching he received there, and looks forward to the type of training proposed today with eighty hours and an exam for the certification. He also emphasized the need for strong outreach for bilingual peers.

16. COMMISSIONER COMMENTS

A. Discuss Future Commission Agenda Items

Chair Van Horn stated that the October 24th Commission meeting will be a single issue agenda - the first read on PEI and INN regulations - and the November 21st Commission meeting will be the second read and adoption of those regulations. He asked what other topics Commissioners would like to see on these agendas.

Commissioner Poaster stated that he would like to see more detail on OSHPD's WET five-year plan when it is ready, in advance of the public showing, and also CRDP strategic plan.

Executive Director Gauger stated that the five-year plan is still at the California Department of Public Health (CDPH). She will be meeting with Dr. Chapman again to talk about the concerns that the chair, vice chair, and staff had with the report.

Commissioner Aslami-Tamplen stated that the November 21st meeting will have a two-hour roundtable on peer respite on the agenda.

Chair Van Horn suggested something around student mental health as a future roundtable discussion.

Commissioner Boyd suggested asking CHFFA to make a presentation on the regulations that they will have rolled out by the November meeting on how they think this is going to fit together as it relates to the different moving parts. Chair Van Horn agreed and stated that it may be good to ask them to present a first read at the October meeting. Executive Director Gauger stated that she has already contacted CHFFA about this, but they have conflicting schedules. She stated that she will contact them again.

Commissioner Boyd suggested, if the scheduling conflict cannot be overcome, having a conference call between CHFFA and the Commission so Commissioners can hear more about CHFFA's new rollout.

17. GENERAL PUBLIC COMMENT

Ms. Hiramoto asked the Commission to support the County Cultural Plan Reports (CCPR), which are being graded by DHCS. DHCS has delayed completing the scoring and posting for one year. She asked the Commission, with its key role, to weigh in and ask DHCS to complete scoring and posting the scores. She suggested having a roundtable of CRDP partners on their strategic plan.

Jim Gilmer, of CMMC, REMHDCO, and the African American Strategic Plan Workgroup, thanked the Commission for having this meeting in Long Beach. He added that it has helped many people attend who normally cannot go to Sacramento. He asked to have more meetings around the state, and acknowledged the many members of CMMC who were in attendance.

Emma Oshagan, Ph.D., member of CMMC and Director of the Armenian Program Development at Pacific Clinics, expressed her appreciation for all the work being done to reduce disparities in mental health in the communities. She emphasized that there are smaller ethnic communities that need more attention, especially in assessing needs and providing services.

Roy Brown stated that peer specialists continue to need support. Just because someone is a peer specialist does not mean they are fully recovered. He also suggested that training peers from each community and culture to do support groups would be more effective than bringing in groups from other communities.

Yvette McShan, the Chief Executive Officer of Operation "Victorious Black Women Corporation," stated that she is a peer specialist and has done mentoring under Commissioner Aslami-Tamplen. She applauded WWT and stated that it will become even greater because of the trust they instill that can help stop stigma and discrimination. She stated that she, as a consumer, can reach other consumers better than other providers that have been in the field a long time, but there is stigma and discrimination between the providers and the peer specialists. She stated that her wish is for the provider and the peer specialist to come together.

Mr. Karmatz announced that there will be a nationwide call at 10:00 a.m. from Susan Rogers of the National Mental Health Consumers Self-Help Clearinghouse on the third Monday of the month. The phone number is 1-800-553-4539. He encouraged panel members to join in that phone call.

18. ADJOURN

There being no further business, the meeting was adjourned at 4:21 p.m.