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State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
November 21, 2013

Citizen Hotel
926 J Street
Sacramento, California 95814

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
Victor Carrion, M.D.
David Gordon
LeeAnne Mallel
Christopher Miller-Cole, Psy.D.
Larry Poaster, Ph.D.
Tina Wooton

Members Absent

Senator Lou Correa
Assemblymember Bonnie Lowenthal
Paul Keith, M.D.
Ralph Nelson, Jr., M.D.

Staff Present

Sherri Gauger, Executive Director
Aaron Carruthers, Chief Deputy Executive Director
Kevin Hoffman, Deputy Director
Filomena Yeroshek, Chief Counsel
Renay Bradley, Ph.D., Director of Research and Evaluation
Deborah Lee, Ph.D., Consulting Psychologist
Lauren Quintero, Associate Government Program Analyst
Norma Pate, Administrative Chief
Kristal Carter, Staff Services Analyst
Cody Scott, Office Technician

1. CALL TO ORDER/ROLL CALL

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:48 a.m. and welcomed everyone. Administrative Chief Norma Pate called the roll and announced a quorum was present.

2. APPROVE THE SEPTEMBER 25 - 26 AND OCTOBER 24, 2013, MHSOAC MEETING MINUTES (ACTION)

Commissioner Buck noted the statement on page 9 of the September 26th Meeting Minutes regarding the percentage of veterans in the inmate population should be attributed to him instead of Commissioner Boyd.

Commissioner Aslami-Tamplen stated her comment was not fully reflected on page 8 of the October 24th Meeting Minutes, wherein she stated Assembly Bill (AB) 1421 “is stigmatizing and not moving towards Health Care Reform in terms of person-centered care.”

Action: Chair Van Horn made a motion seconded by Vice Chair Pating that:

MHSOAC approves the September 25 - 26 and October 24, 2013, MHSOAC Meeting Minutes as amended.

- Motion carried, 11-0

Announce 2014 Committee Chairs and Vice Chairs

Chair Van Horn announced the 2014 Committee Chairs and Vice Chairs. The Cultural and Linguistic Competence Committee (CLCC) will be chaired by Khatera Aslami-Tamplen and vice chaired by LeeAnne Mallel; the Client and Family Leadership Committee (CFLC) will be chaired by Ralph Nelson and co-vice chaired by Tina Wooton and Bill Brown; the Evaluation Committee will be chaired by David Pating and vice chaired by Victor Carrion; the Financial Oversight Committee will be chaired by Larry Poaster and co-vice chaired by John Boyd and John Buck; and Services Committee will be chaired by Christopher Miller-Cole and co-vice chaired by Dave Gordon and Tina Wooton.

MHSOAC 2014 Meeting Schedule

Chair Van Horn referenced the 2014 Meeting Schedule and pointed out that meetings will continue to be held on the fourth Thursday of each month. The odd-numbered months are in-person meetings in Sacramento, and the even-numbered months are teleconference, if needed. He asked Commissioners to keep the fourth Thursday of even-numbered months free around 9:00 a.m. for the teleconference meetings which may only last for one half hour to one hour, but a quorum will be necessary.

Chair Van Horn requested that the Commission meet in Sacramento instead of moving around the state where there is often difficulty getting a quorum. He noted the time of public comment in Commission meetings is limited to fifteen to thirty minutes out of a full day. The quarterly community forums meet around the state and are devoted to hearing from the public. There are three hours of public comment, which is a much better indication of what is happening and how people feel. There are 100 to 300 in attendance at each of the forums, which is much larger than any Commission meeting. The forums also provide a better opportunity for stakeholders and the general public to talk to Commissioners in attendance. Community forums meeting around the state give every county a chance to be involved.

3. INTRODUCTION OF NEW LEADERSHIP FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, AND CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION

Chair Van Horn introduced Karen Baylor, the new Deputy Director of the Department of Health Care Services (DHCS). Ms. Baylor was the county Director of San Luis Obispo for eight years, and, prior to that, she was with (Eastfield Ming Quong) EMQ FamiliesFirst.

Karen Baylor, Deputy Director, Mental Health and Substance Use Disorder Services, DHCS

Ms. Baylor stated she has been Deputy Director of DHCS since the end of August. She expressed disappointment over Executive Director Gauger’s retirement just as she is entering her new position with DHCS, and wished her well. She stated she was struck by Executive Director Gauger’s comment during her retirement party that she has enjoyed every minute of her thirty-three years with the state. Ms. Baylor agreed that it is an honor to be a civil servant and a member of DHCS team, and she hopes to enjoy every minute of it, too.

Ms. Baylor stated she has a license in marriage and family therapy, has been in the behavioral health field since college, and has devoted her life to working with those who have mental illness and substance use disorders. There must be strong partnerships and collaboration between the counties and the state, and that includes this Commission, stakeholders, county partners, providers, advocates, and consumers. She was excited to be in this position, especially at this time of Health Care Reform and other opportunities for change, and looked forward to working closely with the Commission's new Executive Director. She stated she will be happy to come back and provide updates.

Ms. Baylor introduced Brenda Grealish, who has been the Mental Health Division Chief with DHCS since July.

Brenda Grealish, Mental Health Division Chief, DHCS

Ms. Grealish expressed her excitement with the new mental health and substance use disorder services management team. She stated she was with the Department of Mental Health (DMH) for about ten years and, prior to that, she was a student assistant at the Office of Statewide Health Planning and Development (OSHPD). Her passion is for performance outcomes and quality improvement. She worked with the California Department of Corrections and Rehabilitation (CDCR) for about four years, ending up as Deputy Director of the Office of Research.

Ms. Grealish was excited to work under Ms. Baylor. As the Mental Health Services Division Chief, she oversees three branches: program policy and quality assurance; fiscal management and outcomes reporting; and program compliance and oversight. She looked forward to new learning experiences.

She stated she was excited to see the substance use world and the mental health world coming together in health care services. There are many opportunities opening up in networking between departments and divisions. She was happy to have an opportunity to be a part of this exciting time.

Chair Van Horn thanked Ms. Grealish for her involvement with Commission staff and the Evaluation Committee. The new leadership team understands the importance and critical nature of evaluation.

Ms. Baylor stated the alcohol and drug programs were restructured to be part of DHCS. Half of that component is substance use disorder, led by Dave Neilsen.

Dave Neilsen, Substance Use Disorder Prevention, Treatment, and Recovery Services Division Chief, DHCS

Mr. Neilsen stated that he has worked in children's services, suicide prevention, and children's system of care. He has worked for the Department of Alcohol and Drug Programs since 2008. He worked for DMH when the Mental Health Services Act (MHSA) was launched, which was an exciting time and showed the initiative the state had. He stated he looked forward to working with the Commission, mental health, and all of health care services.

Chair Van Horn stated that he has worked with Mr. Neilsen and he is a person of tremendous integrity, and Chair Van Horn was delighted Mr. Neilsen is part of the team.

William Jahmal Miller, Deputy Director, Office of Health Equity, California Department of Public Health

Mr. Miller asked Commissioners to call him Jahmal. He started as the first Deputy Director of the Office of Health Equity (OHE) on October 1, 2013, at the California Department of Public Health (CDPH). He acknowledged the Racial and Ethnic Mental Health Disparities Coalition (REMHDCA) stakeholders in attendance who have aligned with OHE since its commencement.

As mental and physical health, quality of life, and life expectancy areas have improved, there has been persistence in many disparities, specifically with respect to mental health. OHE is honored to tackle, from a policy and strategic perspective, those issues that require reengineering to begin to close the gaps that exist around mental health and to ultimately achieve health equity in the state of California.

One of the three units of OHE is the Community Development and Engagement Unit, which is executing the statewide policy initiative of the California Reducing Disparities Project (CRDP). The unit is completing Phase 1 of the strategic plan for CRDP, and is distributing the Request for Proposal (RFP) for Phase 2, where they will distribute \$60 million over the next four years, allocated to implement the strategic planning recommendations led by five strategic planning work groups. There is a sense of urgency among the stakeholders as well as among Californians to address and implement issues around disparities and ensure that the necessary services and access are afforded to the many Californians who are in desperate need of mental health services.

Mr. Miller stated he has a talented team who are passionate and excited about the work, and he looked forward to continued engagement with the Commission.

One of the other programs tied into OHE is the Health in All Policies (HiAP) team. The HiAP Task Force is an extension of the Strategic Growth Council work. The program management team within OHE leads this work across eighteen departments, agencies, and offices within the state of California, with the understanding, from an upstream perspective, that reengineering will be required at the decision-making and policy-making levels. This is a great opportunity for OHE to partner with other departments, agencies, and offices to embed a health equity lens in every decision and policy created across the state of California, and it ensures a sense of sustainability.

OHE has convened a similar body called the Advisory Committee, which is required by Assembly Bill (AB) 1467. The first meeting was in September, and consists of twenty-four advocates, consumers, and experts advising and informing the leadership within CDPH, Mr. Miller, and OHE regarding OHE Strategic Plan. It will ultimately lead to the first-ever comprehensive strategic plan report that is due July 1, 2014, which will bring to bear OHE mental health disparities approach. Incorporated into the comprehensive plan will be what OHE plans to do to eliminate disparities in physical and mental health. Mr. Miller stated he is grateful to work with the Advisory Committee to achieve this work.

He stated his delight for the level of support from the Director at CDPH, Dr. Ron Chapman. One of the priorities with respect to the strategic plan in CDPH is Goal H, which states OHE wants to achieve health equity through public health programs. It creates a opportunity for OHE and CDPH to operationalize health equity activities within CDPH.

OHE also has a statutorily mandated interagency agreement with DHCS, and Mr. Miller stated he looked forward to working with them to improve mental health disparities in California.

Robert Oakes, Executive Director, California Mental Health Directors Association

Chair Van Horn stated Robert Oakes was unable to be in attendance today because he was meeting with the California Mental Health Directors Association (CMHDA) governing board. Chair Van Horn stated Mr. Oakes was an attorney with the California Association of Private Universities and Colleges, has a good background, and was a good selection to be the Executive Director of CMHDA. He stated he has had several discussions with Mr. Oakes, who expressed his interest in working collaboratively with the Commission on issues that affect mental health. Chair Van Horn stated he looked forward to a long and productive relationship with Mr. Oakes.

Commissioner Questions and Discussion:

Commissioner Aslami-Tampfen commended the presenters for their work. She commended OHE for creating the Advisory Committee and including the voice of the stakeholders. She asked Ms. Baylor if DHCS has a consumer and family advisory committee.

Ms. Baylor stated there was a business plan and a service plan done recently that highlighted that, and Commissioner Wooten has advocated for reinstating an advisory committee. She stated she met with Executive Director Gauger this week to go through DHCS's plan to reinstate that, along with other stakeholder engagement and involvement in issues that have been around for twenty years. She stated she hoped to announce her plan at the next stakeholder call on December 16th and looked forward to pulling that group together again.

4. ADOPT THE 2014 MHSAOAC WORK PLAN (ACTION)

Executive Director Gauger presented an overview of the 2014 MHSAOAC Work Plan. The Work Plan priorities are the same as the 2013 priorities with the exception of Priority 3. Next year will bring rich opportunities to transform the health care system and improve mental health services. The federal Affordable Care Act (ACA) continues to provide opportunities for further transformation by integrating behavioral health with primary care, and the Commission continues to learn from evaluation outcomes and will use these outcomes to shape the system.

The Commission will focus on nine priorities in 2014. Within each of the nine priorities, there are ten to fifteen activities to accomplish. She highlighted a few activities for each priority.

Priority 1: Exercise an active role in policy development

The Commission will develop and consult with DHCS on regulations and policies; monitor activities in the Legislature for opportunities to support, oppose, or advise; and seek to move peer certification forward.

Priority 2: Ensure evaluation regarding the effectiveness of services being provided and achievement of the outcome measures

The Commission will continue to implement MHSAOAC Evaluation Master Plan, to communicate lessons learned and best practices from evaluations, and to improve programs and policy as part of quality improvement feedback.

Priority 3: Exercise financial oversight over the community health system to ensure compliance with statutes and regulations

The Commission will continue to produce semiannual financial reports in January and May, review and report on the recipients of MHSA state administration funds, review CDPH's California Reducing Disparities Project (CRDP) strategic plan, and monitor the status of California Mental Health Services Authority (CalMHSA) expenditures.

Priority 4: Ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of the Commission's decisions and recommendations

The Commission will continue to diversify the methods by which the Commission receives input from people with lived experience of mental illness and explore live streaming of Commission and Committee meetings.

Priority 5: Ensure collecting and tracking of data and information

The Commission will continue to review Annual Updates, Annual Revenue and Expenditure Reports, and three-year program and expenditure plans and cull critical information.

Priority 6: Facilitate relevant and effective support, including training and technical assistance

The Commission will develop an implementation plan for the Technical Assistance and Training (T/TA) policy paper adopted by the Commission, examine options to use evaluation results to demonstrate to taxpayers and counties the successes and challenges of mental health programs, such as a clearinghouse, and oversee appropriate T/TA for issues raised during the process of developing the prevention and early intervention (PEI) and Innovation (INN) regulations.

Priority 7: Provide oversight of statewide projects and processes

The Commission will award and monitor the triage personnel grants, and increase the oversight role of statewide PEI projects.

Priority 8: Increase efforts to communicate statewide impact of MHSA

The Commission will continue to look for ways to collaborate on statewide mental health press opportunities, continue to increase the traffic and utilization of the Proposition 63 website, and communicate the status of reducing mental health disparities.

Priority 9: Continue efforts to develop strategies that overcome the stigma and discrimination associated with mental illness

Under Jennifer Whitney's leadership, the Commission will produce and air a PEI documentary.

Executive Director Gauger stated all of the activities that are within each of the nine priorities will be used to populate the Committee charters, and staff will assume responsibility for the activities that do not naturally fit the charters.

Commissioner Questions:

Commissioner Aslami-Tamplen asked for clarification on Priority 4(e), which states, "Create work group for those left behind in community services."

Executive Director Gauger stated this issue is dear to Commissioner Nelson. It is for those individuals who are "falling through the cracks" and are not benefiting from the Full Service Partnership (FSP) Programs. Priority 4(e) is meant to broaden the outreach so that treatment services can be provided to those individuals. Chair Van Horn added that these individuals may be difficult to identify.

Executive Director Gauger stated Commissioner Nelson will be putting together a work group to address this issue and will bring a recommendation to the Commission.

Commissioner Aslami-Tamplen offered to be a part of Commissioner Nelson's work group.

Vice Chair Pating asked to reword the sentence to use a more positive term than "left behind."

Chair Van Horn stated the intent is clear, which is to have a work group to look at the people who have perhaps been inappropriately served or "left in the dust" as FSPs move forward, where they may have qualified for FSPs at one point but they do not now. This was a major upset for many family members early on. He asked former Commissioner Darlene Prettyman, who was in the audience, to comment on this.

Public Comment:

Darlene Prettyman stated she is certain Commissioner Nelson intended Priority 4(e) to address the seriously mentally ill that are not involved in community services and are being left behind.

Chair Van Horn added these are likely people who are stuck in institutions for mental disease (IMDs), where no one has bothered to take them out of IMDs and bring them back into the community. This has been a problem around the state.

Ms. Prettyman agreed and stated this has been an ongoing problem for the past thirty-four years.

Commissioner Questions continued:

Commissioner Poaster asked if the Priorities are prioritized. Executive Director Gauger answered they are not in any particular order.

Commissioner Boyd stated, as it relates to the Mental Health Services Investment Act of 2013, specifically the outreach workers and the effectiveness of that plan, it is a significant opportunity. He asked if there would be any ongoing oversight of the effectiveness and quality, or the possibility of revising aspects of that plan.

Executive Director Gauger stated, under Priority 7(a), "Award and monitor triage personnel grants," there is, built within the request for application, an expectation that counties will report on an annual basis, and then, in turn, staff will report to the Commission.

Public Comment:

Eduardo Vega, the Executive Director of the Mental Health Association of San Francisco and the President of the California Association of Mental Health Peer Run Organization (CAMHPRO), expressed his sorrow that Executive Director Gauger will be leaving the Commission, and stated her leadership has been significant in many ways.

Mr. Vega stated mental health associations and consumers feel strongly that the Commission's role in bringing leadership and feedback into the discussion about what the future mental health system looks like is essential.

Mr. Vega stated he was excited that the Work Plan includes a focus on stigma and discrimination. There is a misunderstanding about the degree to which stigma works to keep people out of services and isolated, and to further exacerbate the symptoms that people who live with mental health conditions experience.

MHSA is designed to be a community transformative resource, and that is what the Commission has continued to focus on, not just by creating specialized services or activities, but through its whole range of efforts, growing and fostering healthy communities in California. Much of that has been accomplished, but there is still much farther to go.

He asked that the funds dedicated through MHSOAC Client Stakeholder Project be reconsidered so that the framework of that project could be driven towards engagement, education, and involvement of consumers statewide, not through the current evaluation framework. He stated people working in the communities are aware that many consumers feel isolated and are not engaged, either through their local processes or MHSA. He stated the hope that the Commission will help bring consumers back to be core partners in MHSA.

Commissioner Discussion:

Commissioner Boyd asked how effective the 2013 Work Plan was, what percentage of outcomes and objectives were met, and what percentage carried over into the 2014 Work Plan.

Executive Director Gauger stated the outcome of the 2013 Work Plan is reviewed on a quarterly basis. She and her executive management team go through each of the activities within the priorities and consider how they are doing and how the Committees are accomplishing those activities. There are some activities that carry over, like the financial reports, but the Commission completed fifty-seven of sixty-three activities last year.

Commissioner Buck requested that staff provide a checklist of the activities that were completed or are ongoing.

Commissioner Boyd asked how the Work Plan was developed. Executive Director Gauger answered that the new Work Plan is based on what was learned through the years through Committee meetings and feedback from stakeholders and community forums. It begins with direction from the Chair to the Executive Director. The executive team then meets for an all-day

brainstorming meeting, does a final wrap-up of the current year's Work Plan, adds any carryover activities to the new Work Plan, and produces a first draft that goes to the chair and vice chair for input. The first draft is before Commissioners today.

Commissioner Boyd suggested sharing the final wrap-up of the current year's plan with the public, and asked if the findings that were the result of the audit were addressed in the development of the 2014 Work Plan.

Executive Director Gauger stated staff has provided the first sixty-day response to the auditor. All of the recommendations made by the auditor were already underway by the Commission - for example, continuing to implement the Evaluation Master Plan, continuing to dedicate resources to the Evaluation Master Plan, and promulgating PEI and INN regulations.

Commissioner Poaster asked if the report to the auditor will be made available. Executive Director Gauger answered that she would be happy to share it with Commissioners.

Commissioner Poaster asked if the report provides the opportunity to fill in gaps the auditor missed. Executive Director Gauger answered it does not, because the auditor requires adherence to a strict format of succinct responses.

Commissioner Poaster suggested prioritizing this extensive list, and he suggested that Priorities 1 and 2 be combined as the top goal. He stated policy recommendations that come from this Commission should come as a result of outcome evaluations. The unique thing that the Commission does is to provide policy recommendations based on outcome.

Chair Van Horn agreed and added that he is not interested in the Commission commenting on every mental health bill that comes through the Legislature. Priority 1 states the Commission would "monitor activities in the Legislature for opportunities to support, oppose, or advise." He stated any proposal that this Commission submits to the Legislature should emerge from the evaluative efforts and should be selective.

Commissioner Poaster agreed and added that the Commission has always been viewed as an oversight and accountability commission, not as an advocacy organization, which has a different purpose. He stated his hope that the Commission will continue to be selective in regard to comments to legislation.

Vice Chair Pating stated he is not averse to prioritizing Priorities 1 and 2, but, as the Commission will be working on all nine priorities, it did not seem to change the Work Plan much. Under Priority 2(f), the Evaluation Committee will be updating the policy paper, which focuses the Commission on evaluation as a means to oversight and accountability. He suggested bringing the policy paper forward to ensure the Commission stays focused on evaluation.

Commissioner Poaster answered prioritizing Priorities 1 and 2 would be a statement of what is important to the Commission. It would provide clear direction and focus to staff. The Commission, from an overall perspective, is saying that evaluation comes first in its activities. He stated he is suggesting there be a strong statement, both for staff and the community, of what the Commission will be doing over the next year.

Chair Van Horn suggested switching Priority 2 to be Priority 1 so that evaluation is Priority 1, and updating the policy paper so the Commission will not be in danger of becoming an advocacy group, but will promote policies that are the result of evaluation.

Commissioner Brown stated MHSA does mention the Commission's leadership role in mental health policy in California, and, if there is a gap or distinctive lack, then the Commission should exercise that leadership to drive and help shape policy. He gave, as an example, the impact to the mental health community the criminal justice realignment has had, which is not specifically mentioned in MHSA, but there are a number of areas it would fall under that this Commission could address.

Commissioner Carrion stated he pictured Priorities 3 through 9 relating to Priorities 1 and 2 and suggested the possibility of reordering them.

Chair Van Horn stated the Commission has engaged in a joint project with DHCS around fixing the data system. This is critical and has to move forward. By the time of bill introduction, he hoped to be ready to move ahead to sequester some money to fix the data system.

Vice Chair Pating suggested adding intent language so that, in the future, people will understand what was happening when these decisions were made and why.

Chair Van Horn stated he would like to see the motion include switching Priorities 1 and 2 so that evaluation is Priority 1.

Commissioner Brown proposed inserting the word “leadership” in the now Priority 2, “Exercise an active leadership role in policy development.” He stated the Commission should exercise its leadership role as mandated by MHSA.

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

The MHSOAC adopts the 2014 Mental Health Services Oversight and Accountability Work Plan with Priorities 1 and 2 switched in order.

- Motion carried, 11-0

5. SECOND READ: REVIEW AND ADOPT PROPOSED PREVENTION AND EARLY INTERVENTION REGULATIONS (ACTION)

Filomena Yeroshek, MHSOAC Chief Counsel, informed Commissioners that, as staff looked closely at the language of MHSA, it became clear that the language and organization of PEI that has occurred since the beginning, when the DMH set forth the guidance, needed to be better aligned with the language and organization of MHSA.

This is a change and change is challenging; it requires a shifting in the mindset. She stated Dr. Deborah Lee will present these shifts.

The First Shift - Outcomes

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist, stated the first shift is understanding that the PEI section of the MHSA is not a standalone idea, but is part of a broader spectrum that includes treatment for people with serious mental illness whose mental illness is more longstanding.

PEI section of the MHSA, Part 3.6, lists a series of outcomes:

- Prevent mental illness from becoming severe and disabling
- Reduce the duration of untreated mental illness
- Help people regain productive lives
- Improve timely access to services for underserved populations
- Conduct outreach to increase the recognition of early signs and symptoms of mental illness
- Reduce the seven negative outcomes that are consequences of untreated mental illness

PEI section of the Act requires these six outcomes be addressed, but does not specify ways to bring them about.

The Second Shift - Methods

PEI section of the MHSA requires that, in order to bring about these outcomes, effective methods be employed, similar to other approaches that have proven to be successful. There is

a great deal of flexibility in terms of bringing about these outcomes as long as effective methods are used.

A Broader Context

Dr. Lee stated that PEI is the name of this section of the MHSA, which is connected to the rest of the Act in a broader context. It lays out outcomes that require a variety of actions, many of which do not focus on outcomes for specific individuals, but focus on a shift from “fail first” to “help first” - from a crisis-oriented system, where people are already in a point of crisis, to a variety of approaches to help link, identify, and urge people to identify themselves to reach people earlier in the trajectory of mental illness. Dr. Lee gave the example that reducing stigma and discrimination has to do with PEI in a broader context, because reducing stigma and discrimination is critical to helping encourage people to seek services earlier.

The group of actions that is called PEI, Part 3.6, the twenty percent, or “help-first” does not divide itself into “Prevention” and “Early Intervention”, but is a variety of outcomes requiring strategies collectively intended to move to a help-first system, some of which involve working specifically with individuals.

The Requirements in the Regulations and How They Relate to the Range of Outcomes Required by MHSA

Chief Counsel Yeroshek referenced a chart, “Mental Health Services Act: Prevention and Early Intervention Programs,” that ties the requirements in the regulations to the MHSA. The chart contains the language of the Act, and shows whether or not a standalone program is required or whether it is a strategy within a program. The only required standalone program is the program to intervene early in the onset of mental illness as mandated in Welfare and Institutions Code Section 5840.

Section 5840(a) provides the overall purpose of these programs, which is to prevent mental illness from becoming severe and disabling. The Act does not describe how to accomplish that, but intervening early in the onset of a mental illness is one way to do it. Another way is to intervene even earlier, at the point of risk of a mental illness. The reason intervening early in the onset of mental illness is the only required program is because of subdivisions (c) and (d). Section 5840(c) is about regaining productive lives because of the mental health aspects, and Section 5840(d) discusses reducing the impact of the seven negative outcomes on untreated mental health.

These three subdivisions of MHSA are musts - they “shall” do it. There is evidence of significant amelioration of the potentially disabling consequences of mental health by focusing even earlier on reducing the risks related to mental illness. Outreach for increasing recognition is another strategy within a program. The counties have the option of doing either as a standalone program or as a strategy within a program, but it is required because Section 5840(b)(1) states “shall.”

Reducing stigma and discrimination and preventing suicide related to mental illness are optional as standalone programs, because the outcomes under these are provided in other programs.

Changes to the Prior Draft

Chief Counsel Yeroshek stated most of the changes were from Commissioners’ suggestions from the October 24th meeting. Recommendations were also received and incorporated from CMHDA and the public. Commissioner Pating had asked that staff make a chart showing the Commissioner comments, and Chief Counsel Yeroshek directed Commissioners to a chart entitled “Commissioners’ Specific Suggestions for PEI and INN Regulations October 24, 2013, MHSAOAC Meeting.” She pointed out that there was one substantive suggestion that staff did not incorporate because there were conflicting recommendations from Commissioners.

She pointed out that staff received additional comments yesterday from CMHDA that have not been incorporated.

Non-Substantive Changes and Clarifying Changes

Dr. Lee stated most of the changes staff made in response to various requests are what staff refers to as “clarifying changes” - they did not change the intent, but instead made it clearer.

Three programs were renamed. Services for individuals have been differentiated. “Programs to reduce risk associated with mental illness” includes programs that are intending outcomes for individuals at the point of risk of a mental illness, and “programs to intervene early in the onset of a mental illness” includes programs that are intending outcomes for individuals at the point of early onset, as part of the trajectory toward the community services and supports (CSS) and related systems that provide ongoing treatment for individuals with serious mental illness.

Those names were changed, because, since the overall program is named prevention and early intervention, staff felt that to name programs within the overall program the same name would cause confusion. Prevention and Early Intervention is the name of Part 3.6, which includes a variety of things, some of which involve programs that intend outcomes for specific individuals at risk of or with early onset of a serious mental illness.

In response to several suggestions, staff changed the term “gatekeepers” to “outreach for increasing recognition of early signs of mental illness,” which is consistent with the language in the MHSA. Staff also added additional potential gatekeepers to increase the range of gatekeepers or potential responders who could increase recognition of early signs and symptoms.

For the MHSA goal about the “duration of untreated mental illness,” there was a mistake in the previous version of “Improving Timely Access to Services for Underserved Populations.” It was unclear that improving timely access did not necessarily reduce the duration of untreated mental illness for that particular population. It might, to the extent that it overlapped with people in underserved populations who need ongoing treatment for mental illness, but it also included individuals with risk factors where it would not reduce the duration of untreated mental illness, because it had not started yet. Staff added clarification.

Staff clarified the definition for programs to reduce risks related to mental illness, making it clear how the seven negative outcomes apply when intervening at the point of risk, and put more emphasis on reducing risk factors. Staff also clarified when universal prevention efforts would be appropriate.

The phrase “and non-discriminatory” had been left out in a description using non-stigmatizing service delivery methods. Staff also clarified, in a reference to combating multiple social stigmas, that this applies when it interacts with stigma related to mental illness.

Staff made clarifying changes to the definition of effective methods by separating out “promising practices,” and clarifying the definition of “community- and/or practice-based evidence.”

MHSA requires counties to evaluate the outcomes of their programs. One of the changes staff made was to separate out the evaluation requirements for the programs that serve individuals at the point of risk from the programs that serve individuals at the point of early onset, because the ways they are evaluated differ.

Also, staff corrected the requirement to measure changes in attitudes, knowledge, “and/or” behavior, not just “and,” with regard to evaluation of stigma and discrimination reduction programs and broad suicide prevention programs that do not focus on specific individuals.

Staff clarified the intention that the counties designate which of the seven negative outcomes their chosen program is intended to effect, and then measure those outcomes.

Staff suggested defining one outcome in the MHSA, the reduction of prolonged suffering, operationally for purposes of the regulations as the direct mental health outcome element of that program. Dr. Lee explained that it is to ensure every program focuses on preventing serious mental illness from becoming severe and disabling so that programs do not just focus on unemployment, school failure, or homelessness, but also on these things as consequences of unaddressed mental illness.

Substantive Changes

Chief Counsel Yeroshek stated there were two substantive changes made since the last draft. Commissioners requested delaying some of the implementation, because additional items were required from the counties and they needed time to prepare. Therefore, there is a one-year delayed implementation.

Evaluation is the key concern to the Commission and to the counties. She referenced a two-page chart, "Tracking and Evaluation Requirements," which lists, at a glance, the type of evaluation tracking information that is required annually and the type of information that is required over three years. The one-year delay moves the due date of the first annual report with tracking information to December of 2016, and the due date of the three-year evaluation report to December of 2018, which means that the counties will evaluate three years, fiscal year (FY) 2015-2016, 2016-2017, and 2017-2018, with a six-month period after the end of the FY to finish the paperwork.

In addition to the one-year delayed implementation for the evaluation information, the plan requirements were also delayed until the annual update for 2015-2016 because, by the time these regulations are promulgated, counties will have already begun the local community planning process and the public hearing for those proposed plans.

The second substantive change deals with the categories for disaggregating data. This is an area staff is still working on. Chief Counsel Yeroshek thanked Commissioner Carrion for providing his assistance and for pointing out two experts to assist with further categories to disaggregate the current information.

Changes Not Made

Chief Counsel Yeroshek referenced a chart entitled "Mental Illness Policy Organization Comments and MHSOAC Staff Response: Key Concepts." She stated the overarching recommendation was that PEI regulations should encourage specific program features such as Laura's Law. As explained by Dr. Lee, MHSA focuses on outcomes and the use of effective practices, but does not require specific approaches.

Next Steps

Chief Counsel Yeroshek stated, once the Commission approves the draft regulations, the official Office of Administrative Law (OAL) process will begin. Staff will prepare and submit the required documents to OAL, an official notice will be published, and the forty-five-day public comment period will begin. Staff anticipated filing with OAL in early January 2014.

During and after the forty-five-day period, the Commission may have to meet multiple times, depending on the comments received and the Commission's decision whether or not to make any further changes to the proposed initial regulations. Depending on the type of changes made, it may require an additional forty-five days or fifteen days, and then the process will be started all over again.

After the Commission's decision as to whether or not to make changes, the Rulemaking Record, which includes all comments received and the Commission's responses, will then be closed, and OAL will have thirty days to decide if the Administrative Procedure Act was satisfied.

Commissioner Questions:

Commissioner Aslami-Tamplen noted the word “prevention” was crossed out in every part of the regulations, and asked staff to clarify what has been changed with regard to prevention in the current regulations.

Dr. Lee stated the only thing that was changed with regard to prevention in the new draft is that what was previously called a “prevention program,” which was required in Part 3.6, has been given a new name, “reducing risk associated with serious mental illness.” All staff did was change the name and clarify the definition; the content of those prevention programs was not changed.

Commissioner Aslami-Tamplen noted that “treatment or other” was added to Section 1(d)(2)(a)(i), but stated mental health services are treatment. She asked staff to clarify the difference.

Dr. Lee agreed that early intervention or programs to intervene early in onset of mental illness will usually be treatment, but the idea was to ensure it was not limiting - that there was maximum flexibility in terms of how to intervene early, as long as there is evidence that it is effective.

Commissioner Aslami-Tamplen noted that a line was added in Section 1(d)(1)(D) that sounds similar to Section 1(d)(1)(B), and asked staff to clarify the difference.

Dr. Lee stated the line was added, regarding the prevention of relapse at the request from the public, to make it clear that an important purpose of PEI services for individuals was to prevent relapse. She emphasized that PEI regulations do not dictate specific program features, but, generally speaking, an effective approach to intervene early in the onset of a mental illness does include relapse prevention. The additional line makes it explicit that this is included.

Staff had also included language to clarify that relapse prevention was appropriate in programs to intervene at the point of risk and early onset. The reason that is important is that, in the guidelines, it had previously said that if someone had a mental health diagnosis, they could not get prevention services, only early intervention services. But people who have had a diagnosis and are in recovery are still a high-risk group.

Commissioner Aslami-Tamplen asked why the language about reducing risk factors, direct measures of recovery, improved mental health status, and increased protective factors was crossed out.

Chief Counsel Yeroshek stated staff was reluctant to cross out that language, but it is not regulatory language. The same outcome and goal was added in the language above it. There is precise regulatory language and a shift of guidelines to be much broader, but the heart of the language is still there.

Commissioner Buck asked if there is a timeframe on the use of PEI to prevent relapse. He used the example of “John,” at age 55, who has not experienced a psychiatric disability since he went to college at age 18, and is now entering a relapse phase. Commissioner Buck asked if there could be a PEI program designed that would fit the statutes that would impact John at that point.

Dr. Lee stated, in the past, Monterey County submitted a RFP to do a peer support process for individuals who were in recovery to prevent relapse with prevention funds. It was not allowed under the guidelines; it would be allowed under these regulations because it is an at-risk group. John could be in that group and be funded by the program to reduce risk associated with a serious mental illness.

If John were in the early stage of a mental illness, then he could be in a program to intervene early in the onset of a mental illness that would include relapse prevention; or, if John were in the later stage or needed something more ongoing, he could be in a CSS or other treatment

program that also included relapse prevention. Relapse prevention could be included in a variety of ways depending on where John was in his relationship to mental illness.

Chair Van Horn stated another way of saying this is that John, at age 55, has been in recovery for thirty years. He attained a Milestones of Recovery Scale (MORS) level 8 many years back, but all of a sudden, at age 55, he dropped to a MORS level 4. The relapse prevention part is very important right then, and he probably has not been in a CSS program for twenty or more years. There is a sudden situation where relapse prevention is necessary, and that can be funded in this.

Commissioner Carrion asked if efforts to develop programs to prevent mental illness in populations who are high risk are covered within the language. Dr. Lee answered that it would be allowed if there was evidence that the individuals were at high risk, either based on individual factors or being part of a population that had a high risk of developing a mental illness. That is part of the definition of intervening to reduce risk related to mental illness.

Commissioner Mallel asked if family participation will be considered in determining the services for the client in the section that talks about the effective methods of promising practices.

Dr. Lee stated all MHSA-funded services, including those in Part 3.6, are required to meet MHSA general standards, which include client-focused and family-focused services. There are specific standards for that, which include, for example, that parents have to have a leading role in making decisions about their children, and clients have to have a major role in making decisions about themselves. That applies to all MHSA.

There are other regulations that say that clients and family members must be involved in all major decisions related to MHSA, including the programs and the kind of evidence to be used. That is another level that includes that kind of engagement.

Commissioner Mallel asked if there was anything more specific than “improving timely access.” Dr. Lee answered “improving timely access to services for underserved populations” is one of the outcomes in that section of PEI. “Underserved populations” is already defined in regulations. There are many people who are currently excluded from the system. Whatever the service is, it has to include documented efforts to increase access to underserved populations, and they have to report on the outcomes.

Commissioner Brown stated the MHSA indicates that PEI funds could be used for Laura’s Law, but it is not in the draft PEI regulations because of a difference of opinion between Commissioners. He stated his concern that it is the law and it is clear that those funds are applicable and can be used. He referenced page 4 of the chart of Commissioners’ specific instructions, and stated there are at least three other sections in the proposed regulations that mention what funds may be used for.

He requested modifying the language indicating that the funds can be used for Laura’s Law specifically, by inserting language that, in those cases where appropriate, “the funds may be used for judicially-ordered assisted outpatient services for people who do not understand the gravity of their condition,” that mirrors the intent of Laura’s Law and gives it equity in terms of what other things it may be used for that are already proposed in the regulations.

Public Comment:

Ms. Prettyman stated there are cases where persons are placed in IMDs or board-and-care facilities many miles from their home county and family members have no way to visit them. She requested this be added to the prolonged suffering list as something that needs to be addressed.

MaryAnn Bernard, of the Mental Illness Policy Organization, stated this draft represents some improvements and some slippage. Her comments will focus on areas that are still out of compliance with statute. She suggested the Commission reject this motion.

Addressing the question from Commissioner Buck, Ms. Bernard stated there has been language in MHSA since the beginning addressing relapse prevention. The last phrase has been ignored since the beginning of the statute. Relapse prevention programs are vital to seriously mentally ill people and their families. She stated her concern that relapse prevention in the draft regulations is a “may,” but in the statute it is a “shall.” There are no measuring criteria for relapse prevention programs, which mean they have been marginalized. Measurement is necessary and, if there are no measuring criteria for relapse prevention programs, the counties will be afraid to do them.

The statute is not about preventing mental illness, but about preventing severe mental illness. The regulations recite that, and then do not do it. That slippage is critical.

The final slippage is that there is no meaningful measurement in the programmatic part of the statute. She stated her concern that the Commission may suffer abuse like the abuses that have already been well-documented in the press for not measuring success for the programs that are the most vital in the statute.

Beatrice Lee, the Executive Director of the Community Health for Asian Americans, and President of REMHDCO, thanked the Commission for an open, inclusive process for weighing in on the proposed regulations. The draft has improvements in distinguishing between prevention and early intervention. Reaching a diverse population in California is one of the Commission’s Work Plan priorities, and PEI has been effective in reaching underserved populations.

She requested keeping community leaders as one of the potential responders listed on page 1 that have been crossed out. Community leaders are important to reaching new communities that do not trust the system. When the community leader is on board, then the community is on board.

She also requested that Commissioners carefully consider the recommendations in the letter from CMHDA. She stated her hope that CMHDA will have a dialogue with stakeholders such as REMHDCO, because these recommendations will change how the Commission evaluates prevention activities. One of their critical recommendations is not to look at processes as one of the key measures; however, process is important in communities that do not have evidence-based practices. Process is a way to measure whether the community is being reached.

She stated she liked the logic model presented by Dr. Lee, which gives a clear distinction that from prevention to early intervention there is a continuum, and there are different populations that can be addressed in that continuum. She urged the Commission to put more emphasis on the left-hand side of the continuum, because there is not as much funding as for CSS, which are funds for relapse.

Jim Gilmer, of the California MHSA Multi-Cultural Coalition (CMMC), REMHDCO, and the African American Strategic Plan Workgroup, stated Section 2(e) of MHSA addresses effective treatment and support, having a successful model with AB 34, and treating the whole person. The successful programs focus on prevention, client-centeredness, family-focused and community-based services, and culturally and linguistically competent services provided in an integrated system. He encouraged Commissioners to stay aligned to that portion of the statute.

Mr. Gilmer stated communities of color are focused on that paragraph. For the Commission to truly reduce racial and ethnic disparities, it must not only measure the “what,” but the “how.” He stated the need to study the process and contextual factors to better understand the community, communication strategies, and language appropriateness and who is at the table as far as

community leaders. He asked the Commission to review Section 2(e), and to closely consider the recommendations in CMHDA letter as Beatrice Lee mentioned.

Charlene Jamison, of the Alameda County Pool of Consumer Champions (POCC), stated PEI for programs that target chronic homelessness, at-risk populations of dual diagnoses, and MHSA funding for housing, both emergency housing and housing subsidies, is not in place within the program housing guidelines. Housing subsidies and housing are being suspended without PEI ever being implemented. Without PEI, housing is taken away, leaving people homeless once again and at risk of death. The requirements of the program sometimes may only be in the interest of the program or in maintaining hotel program relationships for emergency housing for the success of the program; therefore, they are not focusing on their obligation to reduce the risk of harm to the client participant.

Also, there should be a grievance process for consumers to be heard. The Alameda County Behavioral Health Care Service has only one grievance worker. People who are MHSA consumers do not have a grievance process where they can be heard. It is crucial that they be able to access, through the program, a grievance process that goes directly to MHSAOAC; otherwise, Alameda County, which is funding the programs, will be biased because they want the success of the programs rather than the resolution of the grievances of the participants.

Stephanie Welch, the Senior Program Manager of CalMHSA, stated CalMHSA is the entity that is currently implementing PEI Statewide Projects that aim to prevent suicide, reduce stigma and discrimination, and improve student mental health. She thanked the Commission and staff for including CalMHSA's ability to do some universal prevention efforts. It is a critical approach for reducing stigma and discrimination and in preventing suicide.

She stated she is unclear about the need to move away from using the terms "prevention" and "early intervention." She appreciated that staff is making an effort to distinguish between the two types of services; but, it would provide clarity to stay consistent in the terminology that is used with other funding sources and programs.

She stated the need to make a long-term investment to achieve some of the desired outcomes. The goal of prevention is to reduce risk factors and to supply protective factors by reducing the long-term risk of adverse mental health consequences. Investing three years in a particular service can reveal short-term impacts, such as attitudes, knowledge, help-seeking, and a willingness to provide support or comfort to someone who is experiencing a mental health challenge.

The three-year time period does not reveal changes in normative behavior. CalMHSA has been working with RAND Company for the last two-and-a-half years to develop a process at the state level to eventually track changes in normative behavior that would lead to reductions in the negative consequences of untreated mental illness. RAND estimates it will take five years at the earliest, but Ms. Welch requested that the Commission make a long-term commitment to review them every few years.

She stated CalMHSA is supportive of CMHDA's comments on how to measure suicide prevention and stigma and discrimination reduction on the statewide level.

Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes District Chief of the Los Angeles County Department of Mental Health, representing CMHDA, stated, at the levels of the system, the program, and the client, counties really do want to improve service quality and to intervene early in the course of an illness or prevent a mental illness from happening.

The question is not if evaluation should be done; it is how to do it and who should do it. The draft PEI regulations will take funds away from services to fund evaluation, so better ways must be considered to balance the outcomes.

For those counties conducting stigma and discrimination reduction activities, counties are being asked to measure changes in attitudes and knowledge related to mental illness and to seeking mental health services. Counties are being asked to identify valid measures to accomplish this.

It will be difficult to separate the statewide and the county stigma and discrimination reduction campaigns that have made a difference. Dr. Innes-Gomberg suggested doing a statewide survey to all fifty-eight counties as a meaningful approach to evaluation to counties that will give MHSOAC and the Legislature the information needed to justify prevention and early intervention as valid strategies. She suggested the survey ask questions such as, "Are you more aware of mental health issues now than you were twelve months ago? Did any of these impact your willingness to seek mental health services? If the answer is yes, then why?"

For those counties with suicide prevention activities, counties will be asked to identify changes in behavior and in knowledge about suicide. The information needed to do these sorts of comparisons is beyond most counties' knowledge and expertise. She suggested identifying, either through Workforce Education and Training (WET) regional partnership, evaluation, or CalMHSA, some way for all counties to do this jointly. It needs to be done, but it requires expertise that counties do not have.

For PEI strategy to increase timely access to services to underserved populations, counties are being asked to measure a number of different processes, including the number of referrals, the types of treatment being referred to, and the number of clients who follow through with a referral. Counties are being asked to measure a tremendous amount. These are process measures that should be done through a county and provider question-and-answer processes. She asked if there is an entity that can work with counties on collecting this information and maybe doing a sampling technique. It requires developing a data system and collecting information.

Most counties initiated services in 2009-2010, so the baseline for the duration of untreated mental illness would be different. More staff would be necessary to gather this information, and, if county budgets are not increased, those funds would have to be taken away from providers. The Commission has an opportunity here to work with counties on these issues and to create a robust evaluation for PEI. Dr. Innes-Gomberg stated that she would like to be a part of that.

Vice Chair Pating asked if CMHDA finds the program side of the regulations acceptable, since they are not commenting on them. Dr. Innes-Gomberg stated she has had conversations with staff about this. Many counties are struggling with the new language; it seems a little awkward, as opposed to early intervention and prevention, which are clear. She stated she was pleased that the word "prevention" will be put back into the regulations because that is important; CMHDA's focus is primarily on evaluation.

Commissioner Discussion:

Commissioner Poaster asked staff to respond to some of CMHDA evaluation proposals to give better understanding of the common ground.

Dr. Lee summarized the letter from CMHDA, dated November 20, 2013. One source of confusion is about the terms for prevention and early intervention. Whatever terms are used, it is essential to note that everything in that section does not divide itself into prevention and early intervention.

The second source of confusion is about the difference between the tracking information and the evaluation. The chart shows the required information for tracking for the draft regulations and for evaluation. The purpose of tracking is to answer where the money is going and what the counties are doing. The purpose of the evaluation is to answer what the resulting impacts are.

With regard to statewide surveys and statewide approaches, Commissioners and staff have already indicated they are in favor of the long-term approach of studying statewide outcomes

and the relationship of that to PEI and MHSA programs. PEI and MHSA together are important, but the Act requires counties to measure the outcomes of their programs.

Finally, as mentioned earlier, the major concern is with the lack of data systems, and that is why the implementation was delayed. Staff is working closely with various people, including CMHDA, to move to a more integrated approach. This is a first step. It is essential to emphasize the kind of support and technical assistance that counties will need to help them to do this.

Commissioner Poaster stated the Act requires outcomes, and CMHDA agrees with focusing on outcomes as opposed to process.

Chief Counsel Yeroshek stated there is a terminology issue, because things that are called process measures are really outcomes, from a non-expert point of view. She used the example of the strategy to increase access and linkage to treatment. The number of referrals and whether the individual stayed in the program deal with the goal, the outcome, of that strategy, which is to increase access, and they are not really processes.

Dr. Lee further clarified that the process would be the referral and the outcome would be if the person then sought treatment. The process is the action, and the outcome is the impact of that action, and the chart is divided up that way.

Chief Counsel Yeroshek referred to the chart entitled "Tracking and Evaluation Requirements." There is a misunderstanding because of the change in the organization and the change in the terminology.

Commissioner Poaster stated the chart lists tracking requirements and evaluation requirements. He asked for verification that the Commission currently is focusing on the tracking requirements, and CMHDA is focusing more on the evaluation requirements.

Chief Counsel Yeroshek stated what staff is calling "tracking," CMHDA is calling a "process," and it is not providing enough outcome information.

Dr. Innes-Gomberg clarified that CMHDA is approaching outcomes as though they truly are outcomes of the services and interventions provided. Too many times, clients are engaged in the services but do not recover. The outcome is recovery, symptom reduction, and, for early intervention, no longer needing services.

A county would accomplish this by requiring each provider to indicate, for every early intervention and, presumably, every prevention client that comes in the door, the number of referrals, where they referred the client to, the number of persons who followed through on the referral, the number of referrals that resulted in a successful engagement, and how long the person received services in the program to which they were referred. This takes a lot of manpower, and this is just the gathering of information. The next questions are where to enter that information, what to do with that information at the county level, how it is fed up to the state, and what this Commission does with that information.

Dr. Lee stated it is helpful to understand where the confusion is coming from. MHSA talks about outcomes, not about kinds of programs. The outcome of increasing access to treatment for people with serious mental illness does not necessitate tracking every person in every program; it means figuring out if people show up, and who needs treatment beyond prevention and early intervention. Those individuals are put into treatment, and the outcome is to increase access to treatment for people with serious mental illness, because that is what it says in the Act.

So, it is not taking the idea of a prevention program and an early intervention program and doing things that do not necessarily apply, but it is going back to the specific outcomes in the Act and finding the best way to measure them. If the Act requires increasing timely access to treatment for people with serious mental illness, then that must be measured.

Dr. Innes-Gomberg stated the Los Angeles area has 65,000 clients a year for whom the county and the providers would be required to do this.

Commissioner Gordon stated the original intent of the Act was to explore system changes that would make the overall system more effective. A system that involves processes and the string of events that leads to people receiving treatment is very important in changing the system. Just because something is difficult to do does not mean it is inappropriate to do.

Dr. Innes-Gomberg stated there may be other ways to accomplish this, such as a sampling technique that can be applied to garner the same information.

Commissioner Gordon suggested that counties get together to devise a methodology that is more cost effective and share their resources.

Chief Counsel Yeroshek acknowledged that the draft regulations lack clarity on this point. She clarified that the way the regulations are written allows the county to select how it is measured. It must be an effective method; if sampling is an effective method, then that would be allowable.

Dr. Innes-Gomberg stated the Commission may need to rewrite this, because it asks for total numbers, which means each client would need to be reviewed. She asked the Commission to postpone the vote by one month, because the language changes are substantial enough that it would be helpful, and it would move this process forward in a way that fifty-eight counties could support.

Chair Van Horn agreed that counties are the ones that have to report, but stated the first report is not due until December 2016. He stated he had a discussion with Mr. Oakes yesterday, and the commitment from Mr. Oakes and from the Commission is to get together on this over the next several months while going through this process. Chair Van Horn stated he was not in favor of delaying the vote by a month because that would run into the busy holiday season and would push it back to January. By February, the Commission hopes to have something ready regarding data fixes. He stated he would ask for a vote this morning with the knowledge that the current Executive Director and the new Executive Director would make adjustments in language that are mutually agreeable.

Commissioner Buck stated the need for effective outcomes and a way to demonstrate them. In the new era of health care, every provider has to prioritize what is important. He suggested that counties partner with providers, and stated small providers may need financial or technical support.

Commissioner Poaster asked Commissioner Brown if he would be agreeable to asking Commissioner Buck to comment, as he probably knows more than most people in the state as it relates to the provision of services under Laura's Law.

Commissioner Brown agreed, and stated his objection is that the proposed PEI regulations give three examples of what "may" be funded with PEI funds, but there is no mention whether it is Laura's Law or if there is a preference to not list a specific piece of legislation. The proposed PEI regulations do not state that the funds may be used in limited instances in judicially-ordered community treatment.

Commissioner Buck stated his agency is the Laura's Law provider in Nevada and Yolo Counties. Senate Bill (SB) 585 clarified that MHSA can be used for assisted outpatient services or for anyone regardless of their voluntary or involuntary status. Most of the first sixty individuals brought in under Laura's Law in Nevada County were between the ages of twenty-two and twenty-five. Their first onsets occurred around age fifteen or sixteen, and by eighteen, they had either stopped treatment altogether, or they had such intermittent encounters with treatment that it never sustained any recovery. He stated the Commission's goal for PEI is not necessarily to target people with a long history of turmoil, who oftentimes have gone many years without some sort of recovery and may barely be functioning in the community.

His recommendation was not to focus on using PEI for assisted outpatient treatment, which is a narrow group of individuals. Those funds should come out of CSS in very small numbers and should be done in a recovery model within existing FSPs. He cautioned against widening PEI use resulting in those dollars becoming drained.

Commissioner Brown asked if CSS regulations mention that those funds may be used.

Chair Van Horn answered DHCS is mandated to update CSS regulations and to consult with this Commission during the process, but they are not yet available.

Vice Chair Pating stated these individuals would already have received an assessment and a diagnosis to have gotten to the court stage.

Commissioner Buck agreed that they are people with long histories and are known to the community.

Commissioner Brown stated part of the problem is that they may not necessarily be known to the community. He stated counties do not access the histories of new members of their communities, and would have no knowledge of any untreated severe mental illness. He stated this happened in his county and resulted in the murder of six people. It is a difficult question, because law enforcement picks up the wreckage when people slip through the system. Commissioner Brown asked for assurance that DHCS will include the “may” language in PEI proposed regulations in their CSS regulations.

Chair Van Horn assured that, as this is a statutory issue and falls under CSS, the Commission will do its best to ensure that it is included as DHCS modifies CSS regulations.

Dr. Lee stated the “may” language in PEI section applies to programs, issues, or intended outcomes that are likely to come up in that context. It makes sense to have the “may” language in CSS context where it is likely to come up. It is not likely to come up in PEI context that addresses point of risk or early onset.

Commissioner Boyd asked at what point the decision was made to change the word “prevention.”

Dr. Lee stated because there was confusion over the name PEI in the last meeting, staff decided not to use the term at all because it was reinforcing the old mindset. Prevention and early intervention refers to things like increasing access to treatment for people with serious mental illness beyond PEI, such as reducing stigma and discrimination related to mental illness. She stated staff will change the two parts that address issues for individuals at different points in the trajectory of mental illness back to “prevention” and “early intervention,” instead of “intervening to reduce risk” and “intervening for early onset.”

Commissioner Boyd recommended amending the motion by adding that the language of “prevention” and “early intervention” be reinstated.

Commissioner Poaster stated his expectation that staff will work diligently to address the concerns of the counties that will bear the burden of the regulations.

Commissioner Poaster recommended amending the motion from, “The Executive Director is authorized to approve any necessary non-substantive changes...,” to “The Commission Chair and the Executive Director are jointly authorized to approve any necessary non-substantive changes...”

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

*The Commission approves the Draft Proposed Prevention and Early Intervention Regulations in substantial the form as presented by MHSOAC staff with the following programs name changes:
1 “Program to Intervene Early in the Onset of a Mental Illness” replaces by “Early Intervention*

Program”, and 2) “Program to Reduce Risk Related to Mental Illness” replaced by “Prevention Program”. The Commission Chair and Executive Director are authorized to jointly approve any necessary non-substantive editorial changes and to submit the approved regulations with the supporting documentation required by law to the Office of Administrative Law and proceed as required by the Administrative Procedures Act.

- Motion carried, 11-0

6. SECOND READ: REVIEW AND ADOPT PROPOSED INNOVATION REGULATIONS (ACTION)

Chief Counsel Yeroshek stated the few changes that were made to the draft came from the Commissioners’ suggestions from the October 24th meeting, mainly to require counties to disseminate the final report, which is on page 7.

There was also a request from CMHDA to clarify that adapting a current mental health practice to a different “population” is considered “new,” which is on page 4.

Staff made non-substantive editorial changes on pages 1, 2, 4, 6, and 7; minor clarifying changes on pages 6 and 7; and a substantive change in the race and ethnicity list to make it parallel to the changes made to PEI regulations on page 7.

Chief Counsel Yeroshek stated the next steps and the motion are identical to those presented for the proposed PEI regulations.

Commissioner Comments and Discussion:

Commissioner Poaster requested the motion be made consistent with PEI motion, which gives authority to make non-substantive changes to the Executive Director and Commission chair combined, since there will be a change in Executive Directors.

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

The Commission approves the Draft Proposed Innovation Regulations in substantially the form as presented by MHSOAC staff. The Chair and Executive Director are authorized to jointly approve any non-substantive editorial changes and submit the approved regulations with the supporting documentation required by law to the Office of Administrative Law and proceed as required by the Administrative Procedures Act.

- Motion carried, 11-0

7. GENERAL PUBLIC COMMENT

Helena Liber, from the Client Stakeholder Project, read aloud MHSA Section 75813.5, Part D, and stated there is misunderstanding and ignorance on the part of many people in the general public, providers, consumers, and even on this Commission regarding what recovery service is and what these principles mean. Coercion, forced treatment, and court-ordered aspects of treatment do not fit into the recovery concept, and more education is required. MHSA was passed with this recovery vision, and she exhorted the Commission to adhere to it.

Sally Zinman, representing CAMHPRO, stated PEI is a way of avoiding outpatient commitment, which leads to long suffering and is discriminatory. She stated her concern over the divisiveness occurring at both the county and state levels. People who were working together are now divided and fighting each other, and that is not good for MHSA programs on any level.

She stated the introduction of forced treatment into MHSA is against one of the most vital tenets of MHSA, and she is concerned that, when outpatient commitment is introduced into the mental

health system around the state, it will turn into the same traditional system that is based on forced treatment.

Also, MHSA is based on outreach, and she was concerned, if a person can be forced into the same services that voluntarily-served people have, that outreach would become unnecessary. The Commission needs to be concerned about what mental health services under MHSA will look like five years from now.

Mr. Vega agreed, and stated he supports the directions under PEI with the recognition that it works to prevent the worst effects of mental illness. California is providing leadership to the rest of the country in the vast range of services and supports that are provided through MHSA. Along with that leadership is a responsibility to do things differently, demonstrate results, and create innovations that foster long-term recovery. California can make a bigger impact in the future of health by continuing to look upstream and engaging people where they are early on.

He encouraged the Commission to think even more proactively about what can be done on the state level to engage and provide supports, for resilience, and self-help that start at an early age - not creating programs based on screening or treating children who look like they might have problems, but developing a system in which people own mental health and are empowered to manage their own condition in a positive way from the beginning. He encouraged the Commission to continue promoting that vision and, as it moves forward, showing what a mentally healthy community can look like.

8. CONSIDER RECOMMENDATION TO AUTHORIZE THE EXECUTIVE DIRECTOR TO EXECUTE A CONTRACT NOT TO EXCEED \$700,000 FOR THE DEVELOPMENT OF A CSS TRACKING, MONITORING, AND EVALUATION SYSTEM (ACTION)

Renay Bradley, MHSAOAC Director of Research and Evaluation, stated per the approved Evaluation Master Plan, staff recently issued request for proposals (RFPs) to begin a competitive process to select a contractor for a Community Services and Supports (CSS) tracking, monitoring, and evaluation system. The scoring process is now complete; the Commission can consider approving the Intent-to-Award for this contract.

The Commission has an ongoing commitment to evaluation. There is a statutory role for the Commission to evaluate MHSA as well a broader public community-based mental health system. The creation of CSS tracking, monitoring, and evaluation system is one of the efforts of the Commission to achieve that goal and fulfill the statutory role.

This evaluation project focuses on the CSS component, the largest of MHSA components. It is geared toward provision of client- and family-driven services with a focus on wellness. Housing is also a large part of CSS component.

PEI focuses on individuals who may be at risk for mental illness or those with early signs and symptoms of mental illness. CSS is on the other side of that continuum - once individuals reach a certain threshold they move into CSS and receive services through this MHSA component.

This project will allow the Commission to develop and implement, via a pilot, a tracking and monitoring system for adults who are receiving services within the broader CSS component, and then use that system temporarily to evaluate some of those clients.

Since this is being done within the scope of a pilot, the Commission will use the piloted system to evaluate the efficacy of services for adults who are receiving less comprehensive services than what is provided within FSPs. However, the system will be designed so that it can capture information on FSPs and, potentially, on PEI services that are geared toward direct service to individuals.

The final goal of this evaluation contract is the creation of policy and practice recommendations for how to improve upon the current CSS services, including the evaluation and overarching systems.

Dr. Bradley gave an overview of the contract selection process. On August 30th, staff put out a RFP announcing the scope of work and the deliverables to be achieved via this contract. Staff received six proposals on November 1st, and over the last several weeks has engaged in a scoring process consistent with the California Department of General Services (DGS) procedures. The regulatory requirements have been completed.

She stated there are in-depth scoring processes and selection criteria. After receipt of a proposal, staff does an administrative submission review. Then, staff reviews and scores the qualifications, project narrative and work plan, and cost proposal and makes adjustments to the score calculations for bidding preferences, such as an additional five percent for small businesses. The winner of the contract is the proposal with the highest score.

Proposals were received from six entities: the University of California, Los Angeles, the California Institute for Mental Health (CiMH), the Mental Health Data Alliance; Andrew J. Wong, Inc.; Health Management Associates; and Dr. Andrew Sarkin from the University of California, San Diego.

After completing the scoring process, it was determined the winning proposal was from Andrew Sarkin, Ph.D., the Director of Evaluation Research. Dr. Sarkin is a Clinical Psychologist and Assistant Project Scientist at the University of California, San Diego. He has served as a project manager to provide data analysis and performance monitoring to San Diego County Behavioral Health Services since 2007. Dr. Sarkin oversees the evaluation of the San Diego MHSA PEI and INN efforts, consisting of dozens of programs.

Not only did Dr. Sarkin and his team meet all the minimum and desired qualifications, but he also had a strong staffing plan and highly-qualified personnel. The staffing plan included research scientists, psychologists, and information technology (IT) professionals that will help him to implement the system.

San Diego currently has a system in place called the Health Outcomes Management System (HOMS) that is being used in San Diego and Los Angeles counties to track, monitor, and evaluate PEI and INN services and, in some cases, FSPs. HOMS system has been in development and in use since 2003. Staff is excited to implement this system in additional pilot counties to see if this can be modified and adapted for statewide tracking, monitoring, and evaluation of CSS component, as well as, potentially, other services offered through PEI and INN.

Commissioner Questions and Discussion:

Commissioner Poaster stated Client & Service Information (CSI) is a data system administered by DHCS. He asked in what way are they and the counties involved in this process, and what kind of assurance there is that they would take the results of the pilot statewide.

Dr. Bradley stated, in the initial development stages of this system, the contractor will work with a variety of stakeholders, MHSOAC staff, DHCS staff, counties, and providers, and will consider if client-level information would be relevant to develop within this system to generate a list of the data needs for CSS component from all perspectives. Once that is done, the contractors will work to modify HOMS system so that the Commission can obtain the data from those pilot counties. At that point, it could be further modified, and they would put forth recommendations for how to proceed that ideally will include adopting this at a statewide level.

Commissioner Poaster asked if there are assurances that DHCS, for example, will grant waivers to counties from using the CSI as they participate in this.

Dr. Bradley stated they may not need to stop using the CSI or the DCR. The system is a web-based portal that is adaptable with counties' current electronic health records.

Commissioner Carrion asked if, eventually, all data can be integrated into this system, not only CSS, but FSPs and other programs as well.

Dr. Bradley stated FSPs are a part of the larger CSS component, so the system will include FSPs as well as all other services offered through CSS.

Commissioner Carrion asked why the program is only for adults, and if that is only for the pilot.

Dr. Bradley answered that this evaluation was intended to focus on adults per the Evaluation Master Plan. It focuses on evaluation of services for adults in services that are less comprehensive than FSPs, because there have been other evaluations with FSPs.

At the same time this has been happening at MHSOAC, DHCS has been involved in many efforts within the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). DHCS is creating a performance and outcomes system for children, while MHSOAC contract is designed to create a system for adults, staff envisions a marriage between the two.

Commissioner Carrion asked how the evaluation of children is developed.

Dr. Bradley stated the systems that currently exist do not differentiate between children and adults, and so there are the CSI and the DCR. There is the EPSDT work, which is trying to further identify a system that should be created specifically for children.

Commissioner Wooton asked if the contractor will look at the unserved, underserved, and inappropriately served within CSS program.

Dr. Bradley answered that, within this larger contract, there is one piece of it that is a true evaluation, where, once the system is developed and piloted, the data will be used to evaluate services offered under CSS umbrella for adults who are receiving less comprehensive services than FSPs. It could potentially address the extent to which those services are effective for the unserved or underserved, but may not answer to what extent those populations are being served.

Commissioner Boyd asked about the project time length.

Dr. Bradley stated staff is hoping to execute as of January 1st, and then, because the funds were from this fiscal year, there are three years to spend them before they revert. The project would need to be fully executed and paid for by two and a half years from January 1, 2014.

Public Comment:

Charlene Jimerson stated this Commission is disconnected from what is going on in the consumer level and what the needs are. She stated Janet Brown of the Center of Independent Living requested that she let the Commission know that more services are needed. Ms. Jimerson stated the Commission is using the wrong sources; the focus needs to be on getting information from consumers.

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

Authorize the Executive Director to issue a "Notice of Intent to Award Contract" to University of California, San Diego, Health Services Research Center.

Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.

- Motion carried, 11-0

9. CONSIDER RECOMMENDATION TO AUTHORIZE THE EXECUTIVE DIRECTOR TO EXECUTE A CONTRACT NOT TO EXCEED \$500,000 FOR THE EVALUATION OF METHODS FOR ENGAGING AND SERVING THE TRANSITION AGE YOUTH (TAY) (ACTION)

Dr. Bradley stated the focus of this evaluation is on services, programs, and outreach and engagement efforts for TAY. MHSA requires that programs established in the children's and adults' systems of care include services to address the needs of TAY, aged 16 to 25. Since this focus was put forth, many counties have begun to offer programs aimed at serving TAY and addressing the needs of this very specific population. The extent to which these efforts are effective is not known. Staff is proposing to put forth an effort that would eventually help to identify evidence-based practices for both services for those individuals, as well as outreach and engagement efforts.

Initially, staff will work with the contractors to create a summary and synthesis of county-led TAY outreach efforts, programs, evaluations, and quality improvement designed to strengthen TAY programs and outreach. The contractor will work to develop standard TAY indicators and recommend evaluation and quality improvement methods for TAY programs and outreach. Based on the findings, the contractor will provide technical assistance to improve county-led evaluations of those TAY outreach efforts and services, and to use that technical assistance approach to promote quality improvement processes. This project will help to identify statewide policy and program implications and recommendations that, hopefully, will strengthen TAY outreach, programs, and evaluations statewide.

Dr. Bradley requested that the Commission enter into an interagency agreement with the University of California, San Diego, with Dr. Todd Gilmer as the lead researcher to complete this project. Dr. Gilmer is a professor and acting chief in the Division of Health Care Services within the Department of Family and Preventative Medicine. There are several reasons why staff thought this would be the best approach. First, interagency agreements are exempt from the competitive bidding requirements. Staff learned of Dr. Gilmer via Evaluation Committee members, MHSAOAC contractors, and counties who are currently contracting with him, who highly recommended Dr. Gilmer based on his breadth of knowledge and MHSA-related work. He has conducted prior research on MHSA services and clients, including FSPs and TAY, and is a subject matter expert in these areas. Dr. Gilmer meets the contractor qualifications that MHSAOAC typically seeks out via evaluation RFPs. Using an interagency agreement contract versus going out to bid will allow staff to take more time to work directly with Dr. Gilmer and TAY providers to develop the scope of work and deliverables for this contract.

Commissioner Questions and Discussion:

Commissioner Boyd asked for clarification as to why it did not go out for a RFP beyond the state interagency requirement. Chair Van Horn answered that Dr. Gilmer is probably the best in the state to do this project, and it gave staff the opportunity to deal directly with him when designing the project. The interagency agreement is more convenient and can be more productive.

Vice Chair Pating added that this is part of a larger conversation. The previous study just approved is a capacity-building study; this is a strategic project to identify promising practices. The Evaluation Committee looked at twenty projects and, through a series of discussions, boiled it down to four priorities for next year. In light of the state audit, staff looked at how to find deep, rich material to show that MHSA was working and could lead to improving services.

Last year, the Evaluation Committee presented a report that showed FSPs were effective for adults, older adults, and TAY. Dr. Gilmer showed that TAY had twice and three times the savings of adults and older adults, respectively. The Evaluation Committee found this promising and wanted to figure out what those programs did that made this life trajectory so different for

young adults. He stated his hope that the study will provide quick results that will build on the good work that was done, and will show what is working and why. He encouraged the Commission to support this promising work to get concrete best practices out that could serve and be delivered to any county.

Commissioner Aslami-Tamplen asked if the contracts include consumer and family advisory committees. Dr. Bradley answered that almost all of the evaluation contracts she oversees include, as a contractual obligation, some type of stakeholder advisory committee.

Commissioner Carrion stated his belief that these two projects will augment the evaluation mission. There is one for adults and one for TAY, but, once again, there are none for the children. He recommended strengthening the language in both contracts to consider how they would apply to and enhance the current methods for children. This is necessary data for prevention, so that children do not become adults with chronic illness in the near future.

Commissioner Buck stated his concern that the media would accuse the Commission of a sole-source contract being given out over the protests of other agencies that may want to bid on this.

Executive Director Gauger stated this is not considered a sole-source contract. The Commission has the authority to do that, but the preferred method is to go out to bid. This is considered an interagency agreement that all state departments have the ability to do and is not considered controversial.

Public Comment:

Ms. Prettyman asked if consumers and family members would be included in these evaluation processes. When tracking, monitoring, and evaluating, the Commission needs to be talking to people who have received the services, either successfully or unsuccessfully, so that there is a full range of experiences that would be included. She suggested that the consumers and family members not be handpicked, but that they be receiving some of the services that are mentioned in the contract.

Mr. Gilmer stated the research questions lacked emphasis on the extent to which current TAY programs are culturally congruent and linguistically appropriate, relative to reducing racial and ethnic disparities and increasing access to services. TAY population is critical, particularly the African American and Latino communities. REMHDCO deals with disproportionate minority confinement. Using Commissioner Buck's example of John, John lives in Oakland in five blocks of projects and, because of fear, drugs, poverty, and socioeconomic, psychological, and racial trauma, does not get out of those blocks and projects. He stated the need to ensure that grassroots organizations for racial and ethnic communities are on the forefront of this research for the simple fact that jailhouse mental health services are not culturally appropriate. REMHDCO wants to be involved on the front end of what is effective with TAY population.

Chair Van Horn stated the beauty of the interagency agreement is that this can be worked with and modified. It has built-in flexibility.

Vice Chair Pating added that this came up in the Evaluation Committee as a question from Stacie Hiramoto. Dr. Bradley did confirm that, in all Commission contracts, cultural competency is an established value, principle, and requirement of the contract.

Dr. Bradley stated she looked forward to working with Ms. Prettyman and Mr. Gilmer to identify ways to get the right clients and consumers into the processes as the work continues in the development of these contracts.

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

Authorize the Executive Director to execute an interagency agreement not to exceed \$500,000 with the University of California, San Diego to conduct an Evaluation of Methods for Engaging and Serving Transition Age Youth (TAY).

- Motion carried, 11-0

10. CONSIDER RECOMMENDATION TO AUTHORIZE THE EXECUTIVE DIRECTOR TO EXECUTE A CONTRACT NOT TO EXCEED \$400,000 TO ESTABLISH CONSENSUS GUIDELINES FOR INVOLUNTARY COMMITMENT CARE UNDER WELFARE AND INSTITUTIONS CODE SECTION 5150 AND TRAINING FOR PEACE OFFICERS (ACTION)

Commissioner Poaster and Vice Chair Pating recused themselves from this item for a potential perceived conflict of interest and left the room.

Kevin Hoffman, MHSOAC Deputy Executive Director, stated the 2013 Budget Act appropriated \$400,000 to MHSOAC to develop consensus guidelines for involuntary assessment and discharge regarding Section 5150 of the Welfare and Institutions Code and training as appropriate, which would include peace officers. It was the Statutes of 2013, Chapter 20, that indicated that these funds shall be provided to the statewide and technical assistance entity as contained in Section 4061(a)(5) of the Welfare and Institutions Code, which is California Institute of Mental Health (CiMH). CiMH will be the entity to develop consensus guidelines and provide appropriate training.

CiMH will develop an expert panel and facilitate meetings of this panel to determine parameters of the project, including, but not limited to, change issues to be addressed in the development of consensus guidelines. They will work with all fifty-eight counties to identify representatives from each county to be involved in development of the guidelines. The contractor will determine additional stakeholders and advocacy groups that may be represented.

CiMH will research the current process for clinical assessment to determine appropriateness of involuntary hospitalization and criteria for discharge from involuntary hospitalization in all California counties. They will identify the policies and procedures utilized in counties to assess for and place persons on an involuntary hold, including the identified strengths and weakness of the approaches. They will conduct regional in-person meetings to: a) review current practice, b) receive initial input on current practice and, c) receive input on what is needed to achieve consensus guidelines.

CiMH will review and analyze input received from regional meetings and determine methodology to find common pathways and develop consensus guidelines. They will develop a draft of the consensus guidelines. CiMH will conduct a webinar with the stakeholder participants to include, but not be limited to, review of the draft of the consensus guidelines, and receive comments and input from participants. They will present a draft of the consensus guidelines at CMHDA all Directors meeting, incorporate feedback into the consensus guidelines draft, develop training materials for regional training, and set up and conduct regional trainings for all county and contractor staff responsible for assessment for involuntary hospitalization and discharge.

Commissioner Questions and Discussion:

Commissioner Aslami-Tamplen asked if new consensus guidelines are required because there are no consistent guidelines from county to county. Deputy Executive Director Hoffman answered that this is part of the reason, but it is also because the consensus guidelines have not been reviewed for many years.

November 21, 2013
MHSOAC Commission Meeting

Commissioner Aslami-Tamplen asked if the new guidelines will change anything. Chair Van Horn stated they will not change the law. The guidelines need to be clarified so that they can be more uniform statewide.

Commissioner Aslami-Tamplen asked if the guidelines will come back to the Commission for input. Executive Director Gauger answered that it is not required in order to be approved. In most instances, CiMH would come and present, but it is not for the Commission's approval.

Commissioner Aslami-Tamplen asked if Commissioners will have an opportunity to provide feedback. Executive Director Gauger stated the Commission could request it, but it is not required by law.

Commissioner Wooton asked to request it, if possible, because only CMHDA will review it. There is stakeholder involvement in developing the guidelines, but, when they are completed, only CMHDA would come to a consensus on the guidelines.

Executive Director Gauger stated there would be a group of people that are brought together to develop the guidelines, but she did not believe it was a requirement to have CMHDA's approval.

Commissioner Wooton stated her belief that it should be a broader consensus for the draft of the guidelines than just CMHDA.

Chair Van Horn noted that CiMH is in the audience.

Percy Howard, the Associate Director of CiMH, stated part of the process towards the end is that CiMH is to submit a draft of the guidelines to MHSOAC for review, comment, and feedback.

Commissioner Wooton asked if it was also for the Commission's input. Mr. Howard assured that it was not just for review, but was also for input.

Public Comment:

Steve Leoni, a consumer and advocate, encouraged the Commission to ensure that the consensus is really a consensus. Consumers at the state level and from all fifty-eight counties need to be involved. He stated the need for a facilitation process, because there will be widely differing opinions on this, and it will be hard to put this together and be fair to everyone. This is about consensus guidelines for assessments and discharge, but there is also a need for guidelines on what happens to people in 5150s, because the guidelines for discharge heavily depend on what happens there. Rapid tranquilization is used in many places, but people are traumatized, upset, and confused. It is important to keep any further traumatization to a minimum. Many times, practices are designed in those places that do not do that at all. It sometimes makes people afraid to approach because they do not want to go through all that. What happens between the assessment and the discharge should be considered in the process of forming the discharge guidelines.

Ms. Liber stated Client Stakeholder Project members feel that consumers need to be part of this process. Alameda County has Crisis Intervention Training, which involves police, consumers, family members, and providers. Those four stakeholder groups look at 5150s and crisis intervention. She suggested this model could be spread throughout the state.

She agreed with Mr. Leoni's comments on the need to provide guidelines for what happens while in a facility. She also stated what happens on discharge will determine the course of a person's recovery afterwards. If they are discharged without support, they will not have good outcomes. Alameda County has done pilot programs called Mentors on Discharge, where peers mentor people who were just discharged.

Ms. Zinman agreed with Mr. Leoni and Ms. Liber for heavy consumer involvement in helping to establish the consensus guidelines. The stakeholders are the experts. It is the stakeholders who are being committed, that know how it feels, and that have the experience. She suggested

including a consumer from every county in addition to the other representatives to be involved in this process. The traumatization of forced treatment cannot be eliminated, but the trauma of being involuntarily committed can be decreased by establishing guidelines, especially when consumers are involved in establishing those guidelines.

Ms. Bernard suggested that parents be involved in the establishment of the guidelines, because, many times, they have a different take on involuntary commitment. She encouraged the Commission to ensure that all consumers are involved in the process.

Sandra Marley, a consumer and advocate, suggested that the San Diego County Sheriff's Department may be able to help with some of the training.

Action: Commissioner Boyd made a motion, seconded by Commissioner Miller-Cole, that:

Authorize the Executive Director to execute a contract with California Institute for Mental Health for not more than \$400,000 to develop consensus guidelines for involuntary assessment and discharge regarding Section 5150 of Welfare and Institutions Code and related statute, and training as appropriate including peace officers.

- Motion carried, 8-0, with 1 abstention

11. ROUNDTABLE DISCUSSION: PEER RESPITE CENTERS

Subject Matter Experts:

Yana Jacobs, Program Manager, Second Story Respite House

Adrian Bernard, Second Story Respite House

Keris Myrick, Chief Executive Officer and President, Project Return Peer Support Network

Laysha Ostrow, Executive Director, Lived Experience Research Network (LERN)

Eduardo Vega, Executive Director of the Mental Health Association of San Francisco and the President of CAMHPRO

Chair Van Horn introduced the members of the panel for the third bimonthly roundtable discussion to introduce new topics and new concepts to the Commission. Today's topic is on peer respite centers.

Mr. Vega stated the peer respite center is a program innovation that has been developing across the country that promises to reduce the burden of mental illness, suicides, and hospitalization in a way that is truly driven by the spirit of recovery that MHSA was founded upon.

Options like peer respite fill a crucial need within the system of care outside of the traditional psychiatric hospital or emergency room. These are alternatives in which people who have been there provide support to others, sometimes in a residential setting, sometimes in a short-term setting, where the values and the focus on hope that is driven by people who have been there can help to infuse someone's ability to get through particularly hard times.

The recovery movement has shown for many years that there are alternatives that support people's dignity to help them get through hard times without the requirements of a medical/clinical framework. People in the consumer movement have been developing these alternatives, both from a self-help and a peer support standpoint, for many years. That is the core of some of the recovery values that have driven MHSA, and, as per Assembly Bill (AB) 2034, programs on peoples' ability to recover in the communities of their

choice. Those are Innovative models that drove this Act, and they have been shown to make a difference for people living in the community.

He gave an example of a person who wanted to go somewhere for help, but did not want to go to the hospital and was afraid to call Suicide Prevention, because they would send an emergency response to do something to her that she had been through before and that she found traumatizing. He acknowledged that everyone recognizes that having the police come and put you in the back of a car when you are feeling your worst is not a positive experience. Neither is waiting in the emergency room, getting intense, sometimes multiple, evaluations from multiple providers, or having to tell your story about what you are going through six or seven times in one night. Those are the kinds of things that just do not help.

There is a unique opportunity in peer respite to bring in a kind of support that is community-based and recovery-driven, that meets people where they are to get through the hardest times that they face. He stated his hope that, under both PEI and INN, MHSA dollars will continue to fund peer respite centers, which have been developing across California.

Mr. Vega introduced Yana Jacobs, from Second Story Respite House in Santa Cruz, a peer respite program in collaboration with the county and the Substance Abuse and Mental Health Services Administration (SAMHSA) for some time.

Yana Jacobs

Ms. Jacobs recommended a ten-minute video, entitled "Transforming the Traditional Mental Health System through Peer Staffed Respite Programs," which is about Second Story Respite House, made by Mad in America and posted on the Mad in America website.

She referenced the results of an analysis on Second Story Respite House from the Human Services Research Institute (HSRI), the evaluator for SAMHSA grant, where HSRI concludes, "We have found that staying at the respite reduces the odds of using in-patient or emergency services by seventy-eight percent." The analysis compared 141 individuals over a two-year period with similar diagnoses, age, and utilization of hospitalization pre-respite.

Ms. Jacobs, the Chief of Adult Outpatient Services and Recovery with Santa Cruz County Mental Health, started her career at Soteria House, which is being looked at again as a model for people in extreme states. Second Story Respite House developed as a result of Delphine Brody, the Public Policy Director of the California Network of Mental Health Clients (CNMHC), asking the county of Santa Cruz to apply for a transformation grant through SAMHSA.

Second Story has been transformative on many levels, not just for the people it affects at the house, but for the whole community. It has brought people "out of the woodwork" who never before wanted anything to do with mental health. They are excited and are coming to volunteer, receive the training developed by Shery Mead, and work at the house to help develop this model.

People are choosing to come back to Second Story now after experiencing support from peers who before were considered "frequent flyers" of hospital settings. Ms. Jacobs shared that the amount of patience and compassion brought into a room by people with lived experience is completely different than by staff. At the Second Story startup, the professional staff was cynical about people with lived experience providing support in a safe place for people who were considered to be at high risk. That skepticism was short-lived, and today the professional community refers people to the house for services because they have seen the positive outcomes that result. Ms. Jacobs stated most of the results have to do with people taking ownership of their lives and not feeling so dependent on the system to help them. Second Story has made a difference in the community.

SAMHSA had to cut the transformation grants by fifty percent a year into the project. The county was so committed to continuing the Second Story study that it started using CSS dollars this year to fund half of the project. The county will reevaluate the cost-effectiveness and the impact it has had on people's lives at the end of the five years.

The statewide issue with CSS dollars is that there is not yet a peer certification formal process or Medicaid billing codes for peer specialists. She stated she does not promote peers using current Medicaid codes, because they would have to use the medical necessity model for diagnosis. She promotes peers supporting peers, getting out of the medical model, and not labeling or looking at others in terms of an illness. Ms. Jacobs stated the need for California to find a way to fund peer respites.

Commissioner Carrion asked about the average length of stay and what happens when someone goes to respite.

Ms. Jacobs stated the start-up documents designated an average length of stay to be two weeks, but she recognized a year into the program the benefit that additional time would bring to TAY coming out of their first hospitalization. She asked staff if they could agree to have the guests stay for at least thirty days. TAY are not chronic patients in the mental health system. Going to a peer respite center as they come out of their first hospitalization would be an opportunity for them to learn from peers with lived experience rather than going straight into the traditional mental health system. She has seen some great results with TAY who had an opportunity to stay at Second Story. This is an environment where they can be with people who have been through similar experiences. The length of stay was adjusted especially for TAY.

The program is called Intentional Peer Support (IPS), created by Shery Mead. It is not yet an evidence-based practice with SAMHSA, but it has been incorporated into the evaluation to do a study to help advance it towards being an evidence-based practice. IPS is a five-day intensive training that teaches people how to not think of themselves as junior counselors or therapists, but to recognize what their lived experience is and how to find mutuality in a conversation.

Adrian Bernard

Ms. Jacobs introduced Adrian Bernard, a counselor at the Second Story House, with the National Alliance on Mental Illness (NAMI), and board member of the Santa Cruz Mental Health Client Action Network (MHCAN). She stated Mr. Bernard had been through the IPS training and asked him to share how he incorporates it as he works with people.

Mr. Bernard stated there are moments of truly understanding the shared reality of what it means to go through these experiences, how to bring strengths and weaknesses to the fore, how to find ways of navigating these intense states, and ways to understand one another. It is a shared language of what health is, where boundaries and limitations are, how to honor and express those boundaries and limitations as a house, and how that filters out into the rest of the community. He gave an example of a guest at the house who was able to move away from the system of seeing himself as sick and broken, to moving toward school and away from drugs completely. The miracles that happen in Second Story are profound.

Keris Myrick

Mr. Vega introduced Keris Myrick, the Chief Executive Officer and President of the Project Return Peer Support Network (PRPSN), which is one of the founding CAMHPRO organizations. He stated Ms. Myrick is an amazing change leader, helping to bridge between families and consumers at the national level through NAMI National, and providing leadership and innovations in peer respite.

Ms. Myrick stated she studied peer respites around the country before setting up PRPSN and providing peer services and peer respite. The peer respite concept is not new. In 1992, Ms. Myrick's resident dorm assistant asked her if she would like to stay at a place on the other

side of the campus called the Resident's Place, after she shared about her emotional distress and fear of "going crazy" and being sent to a psychiatric hospital. The Resident's Place is a set of rooms set aside for students in distress, staffed by trained paraprofessionals who were students interested in helping others. Within three to four days of staying at the Resident's Place, she was back in school and completing her Master's Degree. Without even knowing, she was in a peer respite situation, even though that term had not been given to it yet.

In 2010, when she was in the worst place she had ever been, she sent a text to her psychiatrist. He advised that she check herself into the hospital, even though he knew she did not like them, because it was the best place she could keep in touch with him. She felt they were already "in touch" via the telephone and texting, so, when he suggested she check into a hotel instead, she did. She shared this story because she often hears that providers send people to the hospital because they said they needed a break.

When seeking help, the only alternative is often emergency rooms or hospitalization, which creates its own stress and its own expenses. Ms. Myrick emphasized that, up to this point, she had never heard of peer respites, even though she had experienced one and it had saved her life.

Hacienda of Hope is run by PRPSN. It is a short-term, eight-person peer respite center in Long Beach run by peer adults who are living with mental health issues. It is a welcoming, nonclinical environment, staffed by people with lived experience. They offer hope, support, and concrete tools for fostering wellness and managing crisis in recovery. It is a two-story home with nine bedrooms; one of them is fully Americans with Disabilities Act (ADA) compliant. The bathroom on the bottom floor is fully ADA accessible. It has natural light and features a full kitchen, music, entertainment, computer rooms, art, a sunny patio, and a grill.

She stated a lesson learned from hospitalization is that, while in the hospital, everything is taken care of, so when patients are released home, they do not know what to do. At the Hacienda of Hope, guests participate in cooking, household activities, and onsite self-help and wellness groups to help them stay connected to life. They have opportunities to create individualized wellness and recovery plans, and to connect with local resources for employment, housing, and mental and physical health care. They can also take advantage of a co-located resource - a peer-run integrated service management, which is called the Hope Well.

One Hacienda of Hope guest said, "It was a welcoming environment. I felt respected and I loved interacting with staff and the support groups. I could have ended up in the hospital, but Hacienda of Hope provided the support and services I needed to collect my thoughts and get my life on track."

The contract stipulates that each guest can stay up to thirty days. Guests of the house develop a recovery plan based on their stated goals that lead them to seek out or be referred to a respite. Via the Wellness Recovery Action Plan (WRAP), Eight Dimensions of Wellness, walking, meditation, art, and writing, guests have a full array of activities they can choose from to aid in their wellness and recovery - or they can just hang out, rest, or sleep. Many guests have asked if they can come back and volunteer to assist others who stay at the respite.

PRPSN is located within the Century Villages at Cabrillo, a twenty-seven-acre residential community whose mission is to break the cycle of homelessness and encourage self-sufficiency, dignity, and the highest human potential for residents.

Through a collaboration with the Los Angeles Department of Mental Health and the University of California, San Diego, and using HOMS system, several outcome and assessment tools are used to measure behavioral and health outcomes and client satisfaction. PRPSN is also learning from other peer-run models through monthly meetings and the quarterly learning collaborative of all of INN plan programs.

Chair Van Horn stated this is one of the very creative ways of using INN funds for something that has never been done, at least not in Los Angeles. He added there are four different models of INN programs in Los Angeles and multiple versions of each, and he asked Commissioners to consider how these may be applied in their fields, and how these might work in other settings. There are many ways to learn from this and work with it.

Ms. Myrick mentioned some challenges PRPSN has overcome. As previously mentioned, the contract stipulates that guests can stay up to thirty days. When guests were told the stay limit, guests would notably stay up to that limit. To help guests to only utilize the peer respite for the time necessary for them versus just staying up to the limit, PRPSN focused on providing information about the goals they wished to achieve when coming into the house, and providing a Four-Day-Goal Action Sheet, which helped them work toward possibly accomplishing something within four days. Now, the average stay is about three to four days; prior to the Four-Day-Goal Action Sheet, it was two weeks and climbing.

Another challenge was covering costs for the night shift. The contract stipulates that at least two staff will be on duty at all times. At night that became an issue. The night shift must be awake and working. It was assumed that guests would be much the same as in hospital settings - up, anxious, or having broken sleep; instead, guests felt so comfortable and safe that they were sleeping through the night. On the one hand, that was a good thing, but on the other, there is nothing billable. The challenge was how to capture that as a billable service because there was not an "active" fee service.

Another challenge is that capacity is still an issue, because the respite center just opened in July 2013. PRPSN thought of other things to bring in, such as a respite line, which would be like a warm line. Project Return already has a warm line, so they are considering how to bring in a respite line that serves only and is distinct to respite, versus what the warm line does.

Chair Van Horn asked if the learning from this experience of running both a warm line and a respite line has alternate methods of payment. Payment reform is one of the big issues coming up with ACA. He asked if the move will be toward encounter billing, such as episode billings or week-long billings.

Ms. Myrick stated she does not know, but PRPSN is trying to capture data right now. For example, for the overnight, when there are not enough people to provide services to, the staff is keeping logs of what they are doing to help define their work to determine if it might apply to a different type of billable service.

Commissioner Aslami-Tamplen asked if PRPSN has considered applying for triage personnel funding within their county when under full capacity. Those individuals would go out into the community and do more outreach for people who are experiencing crisis.

Ms. Myrick restated the requirement for two persons in the house, although triage personnel funding is a good idea.

Chair Van Horn asked if PRPSN could get the contract monitor to think about using a highly functional guest as one of the two people on a daily basis.

Ms. Myrick stated it might work if the guest identified that this would aid in what they were doing. Two of the things that help people recover most are relationships and meaning and purpose in life. If there is meaning and purpose when a person comes in and they, though now feeling better, are not ready to go back to their situation at home and want to do more than sit in a group or go on a walk, and they start assisting and facilitating a group, that might be something to consider.

Dr. Innes-Gomberg stated, as the contract monitor, this is the model to learn from, and so CMHDA is the most open to looking at alternative ways to fund this. It could be billed on a daily basis if the right procedure code or activity code could be found. The traditional way to bill peer

services is not working anymore, so the contract monitor is interested in the night shift not doing any billing and using invoicing as a strategy. Incorporating the triage personnel is a wonderful idea.

Ms. Myrick stated another innovation PRPSN is working on is trying to promote the use of and educate about health information technology and personal health records by creating a Universal Serial Bus (USB) bracelet with a template in it, which is encrypted and can have the health information a person wishes to put on the bracelet and share with others. Their WRAP plans, psychiatric advance directive, Eight Dimensions of Wellness - anything that they would like on the bracelet can also be uploaded to share with any of their providers, supporters, or family. Guests automatically get a bracelet when they come into the respite.

Vice Chair Pating stated the question of billing and billables is a current issue. With the new expansion of the MediCal benefits, DHCS is looking into what the mental health benefits will be, and the MediCal expansion population will have a social rehabilitation benefit in it. There is a need for movement on this question now.

He stated he does not see why peers cannot begin to expand across the state. There is already a template for this with the Substance Abuse Recovery Homes, where one licensed provider is at the top, and then everyone else is in recovery, but the mental health model has been more staffed towards professionals. The benefit will be designed before January, and, as of January 1st, it should be available across the state. He encouraged not playing around but going ahead and billing things that are billable to get this in the system and move it forward. The lessons PRPSN is learning right now are immediately transferable. They just have to cross this billing hump so that MediCal can adopt some of these different services that are going to be under the new expanded benefits.

A member of the audience asked for the name of the code. Commissioner Wooton answered that it is the rehabilitation option.

Vice Chair Pating agreed and added that, along with the rehabilitation option, a crisis stabilization option will be part of mental health benefits. It is currently being defined, so he recommended that people check in with DHCS to see where it is going and how services might link up.

Vice Chair Pating added that peer respite centers may need to become a little more medical, and the medical model needs to stretch into the peer community. It is a blending and coming together of different continuums of care, but, in the process, peer services will then become mainstream. Again, this is a conversation that must happen and be settled before January 1, 2014. There is a wonderful opportunity right now.

Commissioner Aslami-Tamplen asked how peer respite centers address medication.

Mr. Bernard answered that Second Story does not ask people what their medications are. He added he cannot remember the last time he had a conversation about it other than suggesting it may not be a good idea to go off medication too quickly. It is respecting the fact that people know how to take care of themselves, trusting that they know what they are doing, and honoring the person before anything else.

Ms. Myrick agreed that they do the same thing. PRPSN does not ask about it, but gives every person a lock box to lock up whatever they like.

Laysha Ostrow

Ms. Ostrow, a pre-doctoral training fellow at Johns Hopkins School of Public Health, and the Executive Director of Lived Experience Research Network (LERN), which is a consumer-run national research organization, spoke about peer respite centers from a national perspective.

She referred to Commissioner Pating's comment about the substance use recovery model, where there is a licensed provider at the top, and then everyone else is in recovery in a flattened hierarchy, with peers providing the direct support. In a peer-run model where peers are making the decisions, perhaps having a psychiatrist on staff or in consultation would be useful, but she disagreed that the licensed person should be at the top of the organization.

It is important to have peers in positions of power within these organizations, not just as frontline workers, but making decisions based on their own lived experience and their relationships with their peers. Coming from that place of lived experience rather than professional training creates something different. This population is growing across the country, and there are lessons to be learned from other peer respite centers and the work that they have done.

Peer-run respites are run by an independent organization, usually a nonprofit that has a board of Directors of at least fifty-one percent peers, consumers, survivors, or ex-patients. The Director is a peer and the majority of the staff are peers. Peer-run respites across the country are embedded in a larger peer-run organization.

Peer-operated respites are something like Second Story, which is technically run by the county operating independently and run by peers at the direct level. Those models are often attached to a traditional provider, which can facilitate referrals back and forth if someone should see the need to see another provider.

She stated the need to vigorously document what is going on in peer respite. The Second Story evaluation is a great example of being flexible in the research design but also gathering rigorous evidence, both qualitative and quantitative. There is an opportunity in California not only to fund the programs but to have an evaluation piece built into that from the beginning. Researchers need to be involved with the people who are running and using the program so that the evaluation is informed by those who are there day to day. She cautioned against replicating the power dynamics of top-down hospitalizations and traditional psychiatric care in the research and documentation of what the programs are doing.

Peer support is an evidence-based practice, both in traditional settings with peer specialists and in independent peer-run organizations. There is a substantial evidence base for other non-peer-run crisis intervention, such as Soteria House, which is making a comeback, and there is a new Soteria starting in Vermont. Peer-run respites are places for people to go after they have been hospitalized, but also is a place where young people can go instead of being hospitalized.

There has been one randomized control trial (RCT) of a peer-run respite that was in California but does not exist anymore. They showed significant gains in symptoms reduction and service satisfaction, and the conclusions were generally positive.

Many respites have done qualitative evaluations and have shown positive results in self-definition, patterns of care, and relationships. The Rose House evaluation included a minimal quantitative component where, out of ten guests, seven had not used psychiatric inpatient hospitals since becoming involved with the respite. That is a promising result that needs to be explored further.

Some respites do their own self-evaluations, sometimes to satisfy the needs of a funder, and sometimes to evaluate the impact of their program. She used Afiya, which just opened last year in Massachusetts, as an example. They have developed their own survey to understand guests' experiences, and they also have a Hopes for Stay form that asks people what they hope to get out of their respite stay.

Ms. Ostrow stated Ms. Jacobs did a great job of discussing the Second Story evaluation being conducted by HSRI. There have been many issues in the past with studying peer-run programs using randomization; the observation methods that HSRI is using are a viable alternative to randomization. RCTs can take a lot of financial resources as well as potentially not being

culturally acceptable to programs like peer-run respites or other peer-run programs in terms of the choice component of randomization.

Ms. Ostrow conducted a survey in 2012 of the existing respites focusing on the research tools used and the referrals to and from other services. All of them said that other providers either occasionally or frequently refer people to the peer-run respite. This is important, because occupancy rates are part of evaluating cost, and costs go on even when there are not people there.

The respites were referring people to housing and employment supports, so it is important not only for the respites to be embedded in a larger peer-run organization, like they are doing at Project Return, but also to be connected within the community to support ongoing recovery in terms of employment, housing, family support, WRAP, and other things that people need on a day-to-day basis and not just when they are in crisis.

Program evaluation components that are important to look at are organizational structure, interactions with other systems and stakeholders, cost, outcomes, and a peer-to-peer community resource.

LERN, HSRI, and the National Empowerment Center (NEC) are putting together a toolkit that will document what the existing respites have used across the country in evaluations, outcome monitoring, and reporting data to funders, so that, when new respites open, a respite wants to do an evaluation, or researchers want to partner on an evaluation, they will have some idea what has been used.

Mr. Vega asked Ms. Ostrow for her reflection on the range of billing issues nationwide.

Ms. Ostrow stated most of the peer-run organizations had concerns or were unwilling to take Medicaid, largely due to having to document medical necessity and other requirements, but also due to values-based issues about labeling one's peers. It is hard to say that you are going to have a program that is going to be different than the traditional system or hospital, and then have a financing mechanism that, in fact, can only replicate that in some ways.

One cannot talk about values in these programs and not talk about financing. Most of the existing respites are funded by state and county dollars - block grants and contracts. She stated there is a Senate bill that addresses crisis and MHSA money, which is a wonderful opportunity for the state to fund something so important and necessary. The driver of cost in health care systems, particularly in psychiatric systems, is hospitals and emergency rooms. To bring down costs, there needs to be a reduction in emergency room and psychiatric hospital utilization.

Commissioner Carrion stated the evaluation data from all the peer respites will be critical, because reimbursement may not need to be tied with a diagnosis if one offers a good rationale of something that is effective. Currently it is, but one could make a case for it not being in the future.

Ms. Ostrow agreed and stated maybe it is not tied to diagnosis, but is tied to medical necessity, which means that someone is medically needy, which is inconsistent with the recovery movement.

Commissioner Carrion stated his it could be tied to the effectiveness of a program. Ms. Ostrow agreed, and stated there is a lot of promise with self-directed care and pay for performance initiatives.

Vice Chair Pating stated he comes from a system, as a substance abuse provider, where recovery is the mode of the day. One-third of his staff is in recovery, and one-third of the positions in state organizations are in recovery. He stated he has a great respect for recovery no matter how it is achieved. He has a great respect for the peer movement, wants it to

succeed, and has been an advocate of developing peer certification. In the best-run programs, the person that is licensed is in recovery and has that lived experience.

Vice Chair Pating challenged people to be reflective during this time, because there are opportunities, things to learn, and ways to make a system that is capable of creating a continuum of care that could be quite wonderful for many people. He suggested having a range of peer services, some connecting to the medical system, some not. He recommended looking at all the different opportunities being presented right now, as there will be a great need for peer services in this continuum.

Ms. Jacobs stated the billing issue is critical, because every other MHSA program is able to leverage fifty percent for every MediCal dollar they bring in. It is challenging to have a worthy program with great outcomes, to want to sustain it, and to want to use the same funding sources that everyone else is using, but everyone else is able to leverage the MediCal dollars so that their projects cost the counties fifty percent less. It makes it hard to compete.

Members of the Public Invited to the Table:

Chair Van Horn stated three people have submitted public comment cards. Because this is not a report-and-comment session but is a roundtable discussion, he invited them to the table to share their insights and intersperse their comments into the discussion. Chair Van Horn asked Noemi Castro, Steve Leoni, and Charlene Jimerson to join them at the table.

Noemi Castro, Assistant Director of REMHDCO, thanked the panelists for their presentations, stated it was full of wonderful information, and applauded the Commission for including these roundtable discussions in MHSOAC meetings. She stated she looks forward to this portion of the meeting because it is so rich. She recommended that, for a future panel discussion, an invitation be extended to the seven CRDP partners, especially in light of the forthcoming release of the strategic plan. She stated there will be overlap around what is billable and not billable, community-defined practices, and system change in general.

Vice Chair Pating stated that was a good idea and recommended having the roundtable discussion around the time the report comes out.

Chair Van Horn asked about the status of the report. Ms. Castro stated it is still at Agency level, as they are working out a few kinks in language.

Ms. Jimerson stated her appreciation for Ms. Ostrow's comments about funding. She stated she has been in an FSP partnership program for risk reduction and knows that MediCal manipulation has been done on her part to make her look sicker than she was for MHSA funding.

She stated she feels that the connection with consumers is not there and consumers are not being heard. Consumers need the services in the peer respite centers. The centers are a good way to reduce the cost of many programs that have been duplicated with only a minimum of change. Peer respite centers are a great way to support consumers. She stated she suffers from multiple disorders that cannot fully be covered with medication, and so to have a respite center, to be supported by someone who has been in the trenches and is not just studying the aftereffect, is powerful.

Chair Van Horn stated the Commission is not insensitive to consumer issues. Both he and Commissioner Buck have been in the consumer movement for thirty-plus years. The Commission has two members who are long-time consumer advocates, and their voices are heard in this Commission.

Chair Van Horn asked if Alameda County has a peer-run respite program. Ms. Jimerson stated it does not have one yet.

Commissioner Aslami-Tamplen added that Alameda County is in the process. It is one of the recommendations that the county is putting forward. There are many concerns and gaps in the system, but the behavior health care and health care services agency are in support of the program.

Ms. Jimerson stated she also supports it, and added that it would be a great way to support PEI process also.

Mr. Leoni stated he volunteered for the California Association of Social Rehabilitation Agencies (CASRA) for twenty-five years. There was a bill written in 1978 by then-Assemblyman Tom Bates that regulated the residential treatment setup on the social rehabilitation end, where they talk about having consumers on staff. Senator Steinberg received funds to start a crisis residential program, which is based on CASRA model. Mr. Leoni stated there is more one-time money this year and there is still a need for additional peer respite centers. He suggested people contact Senator Steinberg's office and CASRA.

Chair Van Horn asked if PRPSN has both a peer respite model and a peer crisis house. Ms. Myrick stated the crisis respite house and the peer-run integrated service management are one and the same. PRPSN has also been working with OptumHealth, which is a managed care organization, to study two national pilots, one on the commercial side and one on the public side.

Commissioner Aslami-Tamplen noted OptumHealth has a manual on hospital diversion, entitled "Hospital Diversion Services - A Manual on Assisting in the Development of a Respite/Diversion Service in Your Area."

Mr. Vega stated San Francisco is working to develop an urban approach to CASRA model based on short-term stabilization, as opposed to an extended residential service setting that is provided by Progress Foundation. He stated peer respite is an approach that could fit into current service models as well as being a distinctly different approach in and of itself. Peer respites can help connect to people who might not be in the classic sphere of mental health clients, but are in danger of the worst impacts of mental illness.

Ms. Jimerson suggested that the respite center would be resourceful for co-occurring consumers also, and for trauma-informed care information or education.

Chair Van Horn asked panel members if they are paying equal attention to trauma issues and substance use issues, as well as mental health issues.

Ms. Jacobs stated trauma is one of the foundations of the training and is a big part of how people are acknowledged and supported. Second Story uses a harm-reduction model for the many people that have dual-diagnosis issues and substance abuse issues.

Ms. Myrick stated Project Return has IPS training and Seeking Safety Training. She noted that she heard Dr. Patrick McGorry, the Executive Director of Orygen Youth Health (OYH) and Professor of Youth Mental Health at the University of Melbourne, speak last week on his thoughts on disadvantages of mixing TAY and older adults, especially on keeping folks engaged in hope and employment.

Chair Van Horn agreed and stated that is why TAY is set up as a separate population in MHSA.

Ms. Myrick stated Project Return services are for eighteen and above.

Chair Van Horn stated one of the problems to face in state and federal issues is what to do with 16- and 17-year-olds who really belong with 18- to 25-year-olds. They are one group, but they are under separate laws.

Commissioner Wooton asked if the Commission can form a work group or Committee to study the billing and/or evaluation issues.

Chair Van Horn suggested adding that as part of the 2014 Committee Charters. This gets into the now Priority 2 in the Work Plan, which is public policy involvement. He stated the need to consider who is advocating payment reform, if they are doing it out of self-interest, if there are gaps, and what happens as payment reform is dealt with in ACA as that begins to get applied. There is not enough information on this yet.

Vice Chair Pating stated there is not a need to prove that peer respites work and save money. He encouraged everyone that is involved in the peer movement to get together and ask how to get to the next step, because California has already bought onto this in a major way.

Commissioner Boyd stated the influence of the peer movement shows up differently based on care settings. For instance, he runs a free-standing psychiatric hospital and oversees multiple emergency rooms as related to behavioral health in the Sacramento Sierra region. Five years ago, the psychiatric hospital adopted a recovery model of care within its program development that has now evolved into, starting in 2014, adopting formal peers that will be a part of the care continuum. They have individuals in other formal capacities - licensed and unlicensed - who operate as peers, and they have created a culture and an environment where, based on their comfort level, they can share their stories and be supported through the continuum of individual health, which is culture development. That is taking place within health systems and is starting to inform, on the executive level, some of these broader decisions around investing further in peer support.

Mr. Vega asked the Commission to assign a work group to get people together around these new innovative models, because there is a lot of learning to do about funding.

Public Comment:

Michelle Curran, of Curran and Associates Educational Consortium, stated she is a long-time peer advocate and educator. She thanked the Commission for allowing the members of the panel to present their programs. She works with one of the larger counties in California in establishing both a peer-run respite and a crisis residential program. She supported the panel members' comments, but particularly Mr. Bernard's and Ms. Jacob's comments on the role of training staff and having them informed. Having a trained staff is one of the success components across the nation. Funding is a serious element - to ensure there is a funding capability to train the staff before programs are started up will determine the success of the respite centers and also the success of the people who come and use the services.

12. OVERVIEW OF DRAFT FIVE-YEAR WORKFORCE EDUCATION AND TRAINING PLAN

Lupe Alonzo-Diaz, the Executive Director of Health Professions Education of Office of Statewide Health Planning and Development (OSHPD), stated that Workforce Education and Training (WET) program is a ten-year component. The first WET Five-Year Plan was developed by the DMH in 2008. That plan is from 2008 to April of 2013. Because WET program was transferred to OSHPD last year, the Legislature provided a one-year reprieve for producing the next five-year plan, which will now be due April 1, 2014.

The first five-year plan, from 2008 to 2013, included core components such as statewide administered WET programs, which included stipend, loan assumption, residency, psych residency, and technical assistance; shortage designation; and regional partnerships programs.

The next five-year plan is a five-year plan with a four-year budget, meaning that this FY is year one of that five-year budget, but, because OSHPD was granted a one-year extension, it will be a five-year plan with a four-year budget.

Originally, there was \$445 million for WET programs. Of that, \$210 million immediately went to counties for county-administered programs, and the remaining \$234.5 (sic) million was available

for statewide WET administered programs. Those programs were administered primarily through the DMH and/or contracts with other contractors.

The total dollars available for statewide administered programs for the next five-year plan is \$99.2 million. That figure does not take into account \$9 million allocated separately through a legislative request for regional partnerships, and \$6 million that came to OSHPD unallocated with the transfer of WET program. OSHPD has not spent those dollars, but was committed to saving them until they could be expended in conjunction with the next five-year plan with the existing accompanying budget. As of June 30th the total dollars available is \$114,244.

Sergio Aguilar, the Project Manager for the Five-Year Workforce and Training Plan of OSHPD, stated the plan has gone through several iterations after receiving feedback from California Mental Health Planning Council (CMHPC) and the public.

WET Five-Year Plan provides a framework for strategies that state and local government, education institutions, community partners, and other stakeholders can enact in order to further the development of the mental health workforce. It is an expansive plan; it is not only for OSHPD. OSHPD will be taking some pieces from it, but it is expected that partners will also take pieces that they can incorporate within their programs or can use in the development of new programs.

Mr. Aguilar reviewed one of the major sections of the plan: the goals, objectives, and action section. There are three goals. The first goal is focused on the future workforce, looking at the individuals who are currently in the educational pipeline that will become a part of the public mental health workforce. The second goal is focused on the current public mental health workforce. The third goal is focused on infrastructure and policy.

He highlighted some objectives and actions under each goal. The first goal focused on expanding career awareness and outreach activities, enhancing curricula, developing career pathways, expanding the capacity of postsecondary education, and expanding financial incentive programs.

The second goal is focused on expanding continuing education training, increasing retention, and evaluating methods of existing systems.

The third goal is focused on existing and new collaborations and partnerships, increasing the mental health shortage area designations, enhancing evaluation, and exploring policies that further efforts to meet needs.

OSHPD contracted for assistance in conducting a statewide assessment of WET needs of California's public mental health system, which will be used to inform OSHPD in the development of WET Five-Year Plan. The contractor will provide an analysis of information currently available, an analysis of the county-reported needs, methodologies to do future evaluations, estimates of long-term workforce needs, and an analysis of current statewide WET administered programs.

Commissioner Questions and Discussion:

Commissioner Aslami-Tamplen asked where peer certification falls in the five-year plan.

Ms. Alonzo-Diaz assured that it is in two places. It is in Goal 3 in terms of exploring the policy aspect of the plan. Mr. Aguilar added that, as per feedback from CMHPC, it is also in one of the actions under Goal 1, objective (c).

Vice Chair Pating asked what the reasonable certainty is that enough jobs will be created in the next five years with the \$99 million. He shared that it takes four to five months to fill social worker positions in his company. There are not enough people available for these positions and it will get worse as ACA is implemented. That is a number one priority. He stated the need to

feel comfortable that there are not just big goals, but that there is a definitive plan and a sense of whether or not it will succeed.

Mr. Aguilar stated the things outlined in statute will be funded, such as providing stipends to students who go into the public mental health workforce. The focus is to develop, educate, and train the workforce that will then be employed within the public mental health system.

Vice Chair Pating stated his concern that this approach is a plan to spend money, but does not consider the number of social workers, psychologists, or peer counselors that will be created. He stated the need for people who can run programs. He stated it has been frustrating, because it has been hard to grasp that at a service level or at a level of creating or anticipating what can be done in the future of health care.

Ms. Alonzo-Diaz stated there are data limitations in answering that question or the broader questions about outcomes and impact. In the last five-year plan, there were existing contracts that came over from the DMH that have different strategies, types of data, and outcomes. OSHPD is working with Resource Development Associates (RDA) to identify and document those outcomes.

Based on feedback from CMHPC, evaluation is one of the core components in the next five-year plan. OSHPD will contract with an external independent evaluator and have a measurable element so that, in four years, they will have the data to respond to Vice Chair Pating's question and even the broader questions.

Vice Chair Pating stated four years from now is a little late. It takes about \$1 million to create one psychiatrist, and so ~~nine-ninety-nine~~ psychiatrists or 300 social workers can be created with the \$99 million. That data is necessary to help resource planning throughout the state to have some concrete numbers, instead of putting out programs without being quite sure the target can be reached.

Ms. Alonzo-Diaz stated there will be no more WET statewide administered funds after FY 2017-2018. Evaluation has a two- and four-year strategy with different ways of documenting impacts. For example, OSHPD has a psychiatry residency program, which they support by expanding and adding additional slots, that does not take \$1 million. The contractors are required to provide proof that additional slots have been added as a result of the contract and support from the statewide WET funds.

Chair Van Horn stated the chair of CMHPC indicated that, for the psychiatry program support, payback in terms of public service is not required.

Ms. Alonzo-Diaz agreed that this was the way the existing program was set up in 2008. The majority of the programs that transferred to OSHPD on July 1, 2012, were being administered as a contract to add additional slots to the psychiatry residency program and provide clinical rotations and exposure to the public mental health system, but did not include a service component. The service component includes the stipend and loan repayment strategy, which is part of the discussion in thinking how to do things differently in the next four years.

Chair Van Horn suggested, when considering loan repayment programs, starting a program to provide loan repayment for students as long as they work in public mental health to encourage them to stay in public mental health as long as their loan was being paid off.

Chair Van Horn stated the Commission would like to be involved, and asked OSHPD to provide progress reports to the Commission on the governance, funding, workforce needs assessment, and evaluation plan components, or to involve the evaluation staff in developing the evaluation component and the services staff with the workforce needs assessment.

13. COMMISSIONER COMMENTS

Executive Director Gauger clarified a comment made earlier on the panel. CRDP Strategic Plan is still at CDPH. Commission staff had pointed out areas in some of the strategies that need assistance. Staff has agreed to be part of a small work group with Deputy Director Miller of OHE and CRDP Strategic Plan Work Group members to reword some of the language in the plan. She emphasized that CRDP Strategic Plan is not at Agency. The hope is that the changes will not be significant so that it will not have to go back to Agency.

Chair Van Horn asked staff to include a roundtable discussion with the special population work groups out of CRDP in the near future, as requested during public comment.

14. GENERAL PUBLIC COMMENT

Ms. Marley stated the Center of Disease Control issued a report earlier this year about the increase in suicides in the baby boomer generation, and noted that this is a population that needs to be addressed. She cautioned that this may increase, as there are many people in their fifties that are unemployed and are at the ends of their ropes.

Ms. Liber stated the need for more education around recovery vision, because it is not a concept everyone is familiar with. She suggested that stakeholder meetings or other public formats can provide an opportunity to increase the understanding about recovery vision and the purpose of MHSA.

Chair Van Horn ensured that there would be a portion in each of the four public forums over the next year that would focus on what the recovery vision is about.

Ms. Liber referenced recent radio news, which reported that there were objections to some of the programs that MHSA funded, such as gardening or yoga, and stated those objections are based on ignorance of what the programs were and what MHSA was involved in. For example, the gardening program was for the Hmong community, where they did not have a concept of mental health and mental illness. Gardening was a way of connecting to people who had mental health challenges, which relates directly to MHSA Section 75813.5, Part D, about cultural, ethnic, and racial diversity, and to promoting personal empowerment and social connections. She stated gardening is a way of doing that, and she thought it was very appropriate.

Chair Van Horn agreed, and added that it was also voted as appropriate by this Commission.

Ms. Liber stated the general public does not consider gardening or yoga programs as appropriate because they are not traditional mental health treatments - they do not involve medication or professional psychologists and psychiatrists. Commissioner Aslami-Tamplen agreed, and added that the public thinks treatment should take place in psychiatric hospitals, not out in the community.

Ms. Liber stated there are people in the public who do not understand the recovery vision and the importance of alternative types of approaches, especially in communities that do not have traditional views about mental health.

Mr. Gilmer agreed with Mr. Miller of OHE about creating equity, and stated he was glad the Commission was putting CRDP as an agenda item in 2014 to help foster collaboration and equity. Oftentimes, other perspectives are given primacy over racial and ethnic perspectives. He encouraged the Commission to give racial and ethnic perspectives an equal place at the table to bring diversity and additional depth to the work of the Commission. He affirmed, on behalf of REMHDCO, the desire to continue to effectively collaborate with the Commission.

Vice Chair Pating announced that this was Executive Director Gauger's last Commission meeting. He thanked her on behalf of MHSAOAC for all she has done for the Commission for the past three years, and wished her well in her retirement.

November 21, 2013
MHSOAC Commission Meeting

15. ADJOURNMENT

There being no further business, the meeting was adjourned at 4:40 p.m.