



State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting
October 23, 2014

MHSOAC
1325 J Street, Suite 1700
Sacramento, California 95814

Tel: 866-817-6550; Code 3190377

Members Participating

Richard Van Horn, Chair
David Pating, M.D., Vice Chair
Sheriff William Brown
John Buck
Paul Keith, M.D.
Christopher Miller-Cole, Psy.D.
Ralph Nelson, Jr., M.D.
Larry Poaster, Ph.D.
Tina Wooton

Members Absent

Khatera Aslami-Tamplen
John Boyd, Psy.D.
Victor Carrion, M.D.
Senator Lou Correa
David Gordon
Assemblymember Bonnie Lowenthal

Staff Present

Sherri Gauger, Interim Executive Director
Kevin Hoffman, Deputy Executive Director
Filomena Yeroshek, Chief Counsel
Renay Bradley, Ph.D., Director of Research and Evaluation
Deborah Lee, Ph.D., Consulting Psychologist
Jose Oseguera, Chief of Plan Review and Committee Operations
Norma Pate, Chief of Administrative Services
Kristal Carter, Staff Services Analyst
Cody Scott, Office Technician

1. CALL TO ORDER AND ROLL CALL

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:35 a.m. and welcomed everyone. Kristal Carter, Staff Services Analyst, called the roll and announced a quorum was present.

ACTION

1A: Approve September 30, 2014, MHSOAC Meeting Minutes

Action: *Commissioner Nelson made a motion, seconded by Commissioner Miller-Cole, that: The MHSOAC approves the September 30, 2014, Meeting Minutes as presented.*

Motion carried, 8-0

INFORMATIONAL

1B: September 30, 2014, Motion Summary

1C: MHSOAC Evaluation Dashboard

1D: MHSOAC Plan Review Dashboard

1E: MHSOAC Calendar

ACTION

2A: Approve Prioritized Evaluation Activities for Fiscal Year (FY) 2015/16 and Update on Current Evaluation Activities

Presenter:

Renay Bradley, Ph.D., MHSOAC Director of Research and Evaluation

Renay Bradley, Ph.D., the MHSOAC Director of Research and Evaluation, presented the background of the prioritization process as outlined in the MHSOAC Evaluation Master Plan and recently revised by the Commission. The Evaluation Committee and staff, using the revised prioritization process, recommends six potential priority evaluation activities for FY 2015/16:

- effectiveness of peer/consumer-led/run services
- impact of the Mental Health Services Act (MHSA) on children, youth, and families
- evaluation of outreach, assisted outpatient treatment (AOT), and Laura's Law
- effectiveness of screening for substance use disorders
- examination of factors that lead to prolonged duration in full service partners
- literature review of best practices in peer support, employment, and crisis services

Counties now have the ability to use MHSA funds to implement Laura's Law. The Commission would look at whether or not outreach strategies could help to avoid having to use Laura's Law. The evaluation would also evaluate the impact of court-ordered treatment and Laura's Law and whether that facilitates positive outcomes.

Commissioner Questions:

Commissioner Wooton asked if the Commission would also evaluate the effectiveness of the Senate Bill (SB) 82 Grants issued to counties for crisis intervention.

Dr. Bradley stated within the SB 82 Triage Grants, the Commission required counties to evaluate those programs. The Commission will monitor those reports, but the inclusion of evaluating the SB 82 Grants within the prioritization activities could be explored.

Commissioner Nelson asked if there are enough counties participating in Laura's Law and if they have enough data.

Dr. Bradley stated the prioritization activities will not begin until July 1, 2015, and it could take nine to twelve months after that to begin collecting data from the counties. This prioritization activity is coupled with outreach to evaluate the effectiveness of Laura's Law and to determine if there are ways to prevent the necessity of using AOT at all.

Commissioner Poaster asked for clarification on the evaluation of AOT and Laura's Law priority activity.

Dr. Bradley stated there was a proposal that the Commission should look at community services and supports (CSS) and prevention and early intervention (PEI) outreach activities. Less evaluation has been done on indirect strategies like outreach that are helpful in treating patients. This priority activity will study the efficacy of outreach within CSS and PEI, as it pertains to the use of Laura's Law. Another component will study the efficacy of Laura's Law. A robust evaluation of individuals who have been mandated to go into treatment may or may not be possible. Any data would have valuable policy implications because counties can use MHSA funds to implement Laura's Law.

Commissioner Poaster asked what a likely finding would be.

Dr. Bradley stated findings would be determining if there are county-implemented outreach strategies that result in effective treatment and increased access to services for the unserved, underserved, and inappropriately served; measuring the outcomes of the outreach strategies; and determining the outcomes associated with involuntary treatment.

Commissioner Poaster asked if Dr. Bradley sees it as evaluating two competing methodologies.

Dr. Bradley agreed that it would have two pieces. The generic outreach can be assessed in every county, while the Laura's Law piece can only be assessed in counties that have implemented it.

Commissioner Poaster stated there is a body of literature available. He suggested looking at those studies to glean what is applicable.

Dr. Bradley stated she briefly reviewed the literature. The results suggest it is not effective to mandate the laws.

Commissioner Poaster stated few studies have been done in California. This is a huge controversial area. The Commission should think about forming clear expectations.

Commissioner Buck stated everyone wants voluntary treatment whenever possible. He encouraged the research despite the controversy. After almost six years, Nevada County is rich with data on AOT and is happy to share it.

Chair Van Horn stated this came out of a two-day meeting in Washington, D.C. with the Substance Abuse and Mental Health Services Administration (SAMHSA) to look at the effective use of AOT. Mark Ragins, the Medical Director at Mental Health American of Los Angeles, and Brian Stettin, the Policy Director at the Treatment Advocacy Center, which is the Fuller Torrey group, and the Director of SAMHSA have an interest in being involved in this kind of study in California. The study would be a comparison and would involve both sides in the process.

Commissioner Keith stated there are many studies on the effectiveness of screening for substance use disorders.

Dr. Bradley stated the Evaluation Master Plan describes doing pilot studies within counties to determine the efficacy of screening tools. If screening tools have been developed and tested and that step is not necessary, then the Commission may not need a large-scale study.

Vice Chair Pating agreed that there are many studies on standardization of screening. It is a national best practice, but only about ten percent of systems are screening. The questions are why, who is doing it, where it is being done, how effective California systems are at implementing it, and where the Commission could best impact it.

Commissioner Nelson suggested evaluating each county. There are many good screening tests, but some counties are not using sufficient screening.

Commissioner Miller-Cole suggested asking counties what the barriers and challenges are to putting effective screening in place.

Dr. Bradley agreed that the question of barriers and challenges could be added to the county survey. She stated this prioritization activity would not fully explore the efficacy of screening tools, but rather learn the tools that counties are using and strengthen those tools based on a literature review of best practices.

Commissioner Poaster agreed that there is no reason for a large-scale study if there are already validated instruments. He asked if this evaluation priority tied in with Vice Chair Pating's Commission-adopted policy paper on co-occurring disorders.

Vice Chair Pating stated the policy paper would support this kind of work as it promoted screening and looking at implementation issues.

Chair Van Horn asked Dr. Bradley to bring this back to the Commission after designing a tool to ask for updates and for the barriers and implementation challenges encountered by counties.

Public Comment:

Erin Reynoso, the Associate Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated her concern that there is little mention of evaluation activities that address racial, ethnic, and culturally underserved populations in these recommendations. Reducing disparities requires evaluating how successful methods are at doing so.

Rocco Cheng, Ph.D., the Corporate Director of Prevention and Early Intervention Services at Pacific Clinics, stated the need to continue monitoring the effort put into the MHSA funds and how it has reduced disparities. He encouraged ongoing efforts to look into what the best service is for diverse communities, and recommended monitoring the effort on reducing disparities.

Vice Chair Pating asked how that differs from what has already been done in the Strategic Planning Workgroup (SPW) California Reducing Disparities Project (CRDP) reports, as well as the research that would be done to test the hypothesis proposed with the CRDP evaluation element.

Dr. Cheng stated the CRDP focuses on the promising practices in five population areas. He suggested also looking at the system that county mental health has in place. In his county, the only emphasis on PEI is evidence-based practice. It is so costly that it is almost non-sustainable for contractors. Additionally, evidence-based practices may initially improve samples from diverse communities, but the percentage is small. Implementing a program that has biased sample subjects for the entire community will not work. The CRDP is focused on nurturing community-defined evidence. Dr. Cheng recommended looking into the public system to examine ways to support the development of community-developed evidences, and ensuring that traditionally-defined evidence is not the only way of providing sufficient evidence.

Reina Florez stated she supported the previous speakers. She emphasized the importance of listening to both providers and recipients.

Jim Gilmer, of the California MHSA Multi-Cultural Coalition (CMMC) and REMHDCO, stated he supported the previous speakers. He stated the evaluation framework is not intentional about including focus on reducing racial and ethnic disparities. He stated the terms “peer/consumer” in the evaluation priority to evaluate “peer/consumer-led/-run services,” are not relevant. Instead, cultural brokers, cultural ambassadors, promoters, pastoral counselors, lay counselors, lay ministers, parish nurses, and natural helpers form many of the aspects, beliefs, and pathways of healing for cultural and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities.

Mr. Gilmer asked how data will be disaggregated for African-American and other SPWs in the evaluation priority to increase support for children. He stated he saw no mention of faith-based or diverse strategies in the AOT and Laura’s Law priority activity. He encouraged segmenting strategies to each population’s pathways to healing. He hoped this effort will work closely with the seven CRDP partners as diverse communities want to be involved in the reduction of racial and ethnic disparities.

Dr. Bradley assured that one of the main goals of the MHSAOAC is to address reducing disparities. Through the initial assessment on whether or not the MHSA has reduced disparities, it became clear that the necessary data is not available at this time. Staff will propose that, as part of the Work Plan for next calendar year, the Commission will work with stakeholders to develop a framework to assess the progress toward reducing disparities and access to care. She stated the desire to connect with the CRDP to develop this framework, but it is not the appropriate time.

Commissioner Discussion:

Commissioner Nelson stated stakeholder input at a community forum in Nevada County indicated that Laura’s Law works as an outreach mechanism for voluntary treatment, because more than fifty percent of the people who were engaged in the beginning of the process in Laura’s Law volunteered to do treatment and were never placed in Laura’s Law. He stated the need for the study to include individuals that were not placed in Laura’s Law even though they began the process there.

Commissioner Buck stated Nevada County has been gathering extensive data through the referral process. He stated, of the more than eighty individuals referred in the last six years, nineteen were court-ordered.

Commissioner Brown suggested publicly recognizing the importance of reducing disparities and encouraging that steps be taken between now and next year to gather the type of data that is needed to do an overall evaluation next year. He stated it may cross over into some of the other priorities.

Chair Van Horn agreed and stated the Commission is waiting for the CRDP plan to be approved at Agency to better understand what the state is planning to do on a statewide level. It may be appropriate to have a general paragraph in relation to the year's evaluation efforts that notes that diversity and disparity issues will be considered as they occur in each of the approved programs.

Commissioner Nelson suggested removing "peer" from "peer/consumer-led-run services" in priority activity one.

Commissioner Wooton asked to add the terminology that Mr. Gilmer suggested - cultural brokers, cultural ambassadors, promoters, pastoral counselors, lay counselors, lay ministers, parish nurses, and natural helpers - because many people are unfamiliar with the terms. She asked why the funding amount was larger for the Laura's Law evaluation.

Dr. Bradley stated all budgets are anticipated. The Laura's Law evaluation is a larger study because it is many studies in one.

Vice Chair Pating asked staff to refine the language for the screening for substance use disorders evaluation to narrow the focus and the peer services to include additional terminology. He asked that cultural diversity and reducing disparities issues be considered for incorporation into the Work Plan.

Dr. Bradley stated there is a contractual obligation with every evaluation to assess racial and ethnic demographic groups when possible. Staff plans to propose the inclusion of a focus to determine when the appropriate time will be to study reducing disparities and what can be done in the meantime and where to go in the future.

Commissioner Miller-Cole stated the evaluation of AOT and Laura's Law is an opportunity for the Commission to show leadership. The fact that it is controversial is, in this case, an argument to do it. It could help the community and the state with the discussion to put some data with it.

Commissioner Poaster agreed.

Commissioner Buck stated he loved Commissioner Miller-Cole's statement. Evaluating AOT and Laura's Law does not mean the Commission supports it. It is just a study. Part of the justification for those who say they support it is that they believe it works. Part of the justification for those who are concerned or in opposition to its implementation is that they believe it does not work based upon other studies in other countries and municipalities. He stated for that reason alone the Commission should study what is being done in California and, if the study concludes it does not work in California, the Commission can take the appropriate action at that time.

Commissioner Brown asked if this would particularly evaluate Nevada County's program, which has been up and running for a while, because many of the counties that are coming online have programs in their infancy or have had inconsistent programs.

Chair Van Horn stated it will look at what has been learned in Nevada County, what is now beginning to be learned in other counties, and the conclusions reached at the end of two to three years. It is a broad scope and involves the Treatment Advocacy Center and the SAMHSA.

Action: *Vice Chair Pating made a motion, seconded by Commissioner Miller-Cole, that:*

The MHSOAC approves the staff-recommended prioritized evaluation activities for Fiscal Year 2015/16; however, priority #1 (Evaluation of the Effectiveness of Peer/Consumer-Led/Run Services) and priority #4 (Evaluation of the Effectiveness of Screening for Substance Use Disorders) will be refined to reflect the Commission's concerns voiced at the October 23rd meeting.

The Commission recognizes the need to assess the disparities in access to mental health services and the lack of data and as such instructs staff to include in the MHSOAC Work

Plan for 2015 the development of an evaluation framework for assessing disparities in access to care statewide.

Motion carried, 9-0

ACTION

3A: Consider Recommendation for a Contract to Develop a Feasibility Study Report (FSR) or Advanced Planning Document (APD) to Evaluate the Department of Health Care Services (DHCS) Behavioral Health Data Systems

Presenter:

Renay Bradley, Ph.D., MHSOAC Director of Research and Evaluation

Dr. Bradley spoke about the Commission's statutory role to do evaluation, the lack of accurate data to accomplish this task, and the Commission's data-strengthening efforts to date. She outlined staff's proposal to identify, assess, and develop recommendations for the required data. She then reviewed the scope of work and deliverables, and the qualifications of Stewards of Change Consulting, LLC, and the Public Consulting Group, the proposed contractor and subcontractor for this study.

Commissioner Questions:

Commissioner Keith asked if this project will result in a specific platform that will carry out the operations that have been described.

Dr. Bradley stated there are two types of APDs that can be done: a pre-APD and an implementation APD. She gave an analogy that the pre-APD is a house and the implementation APD is the blueprints for the house.

Commissioner Keith acknowledged the need for the "blueprints," but stated they come at a cost of approximately \$10 million to \$100 million. He asked where that money will come from.

Dr. Bradley stated that is part of the work the Commission will have to do. In the end, the contractors will provide a recommendation. She stated the hope that the DHCS and the California Health and Human Services Agency (CHHS) will adopt it, but it is the Commission's due diligence to begin the process for ensuring that that support is available via the Legislature. The APD will be completed in February 2015.

Commissioner Nelson asked how this integrates with the data elements that other universities are working on and how a system can be decided upon without knowing the necessary data elements.

Dr. Bradley stated the Commission has a contract with the University of California, San Diego, which is studying that for the CSS component. The PEI Regulations list the statewide data indicators that counties are expected to provide for the PEI component. The state requires minimal indicators for the MHSA components for which counties must measure and collect information in a consistent and systematic way to be regularly shared with the state. Currently, there is no system to get that data to the state, and the state-level data elements are not readily defined for the MHSA components.

Commissioner Poaster asked if the DHCS was committed to this.

Dr. Bradley stated the DHCS appears committed. Staff has been meeting with the DHCS and the California Mental Health Planning Council (CMHPC) to put together a charter to help facilitate support.

Commissioner Miller-Cole asked where the counties fit in, since they are ultimately the ones who will have to implement this. It would be easier to sell it to them if they are involved.

Dr. Bradley summarized the many ways that counties can be involved.

Public Comment:

Yvette McShan, of the CMMC and Victorious Black Women, asked what the Commission would do differently with the new contractors.

Chair Van Horn stated the Commission is looking at overhauling the state data system, which is a legacy system.

Commissioner Poaster stated there are three different processes occurring: the work that UC San Diego is doing in identifying data elements, this evaluation, and the counties' electronic health records (EHR). There are hundreds of millions of MHSA funds that have already been spent on EHR systems pursuant to the Act. It is important to consider this in designing other systems to maintain consistency. He stated his hope that the CHHS and the DHCS will help to identify where the resources will come from.

Dr. Bradley stated the goal is to figure out a system that the county EHR systems can connect to.

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

The MHSOAC authorizes the executive Director to execute a contract with Stewards of Change Consulting, LLC, for not more than \$300,000 to develop a State Feasibility Study Report (FSR) or a Federal Advanced Planning Document (ADP) to assess the current DHCS behavioral health data systems.

Motion carried, 8-0

ACTION

4A: Prevention and Early Intervention (PEI) Regulations: Responses to Public Comment on Selected Sections

Presenters:

Filomena Yeroshek, MHSOAC Chief Counsel
Deborah Lee, Ph.D., MHSOAC Consulting Psychologist

Filomena Yeroshek, the MHSOAC Chief Counsel, stated today's presentation is the last of the public comments received during the forty-five day public comment period. The last four sections of the PEI Regulations – Sections 3560, 3560.010, 3560.020, and 3750 – deal with the requirements and reporting for evaluations. Ms. Yeroshek spoke about the order of the presentation and gave a brief recap, an overview of the next steps, and a summary of the suggested changes to the PEI Regulations.

Staff's Suggested Changes

Deborah Lee, Ph.D., the MHSOAC Consulting Psychologist, reviewed a document titled, "Proposed Changes to Sections 3560, 3560.010, 3560.020, and 3750 Presented at the October 23, 2014, MHSOAC Meeting." She stated most of the changes are non-substantive. She went through the document, pointed out each change, and stated the reason for that change.

Commissioner Keith referenced Section 3560.010(b)(3)(E), the deleted requirement to report how long individuals received services in a program. He suggested the addition of the number of individuals that complete a treatment.

Public Comment:

Dr. Cheng stated his support for Section 3560.010(b)(5), the incorporation of the collection of disaggregated data. He suggested adding "Southeast Asian" to the list. He also stated his support for Section 3560.010(b)(4)(D), (F), and (G), the timely access to services experienced, especially by the diverse community. Dr. Cheng agreed that the Commission should take a leadership role in doing some trend reports on the statewide data issue, and he encouraged the Commission to continue to look into disparities in diverse communities.

Ms. Reynoso echoed Dr. Cheng's comments on the disaggregation of data. She stated her support for Section 3750(g)(3)(A), the duration of untreated of mental illness.

Michael Helmick stated his support for Section 3560.010(b)(5), the incorporation of the disaggregation of the data.

Poshi Mikalson, of Mental Health America of Northern California, and Project Director of the California LGBTQ Reducing Disparities Project, stated her support for Section 3560.010(b)(5), the incorporation of the disaggregation of the data, and thanked staff for adding sexual orientation and gender identity into the data collection. She suggested that staff meet with subject matter experts to determine appropriate identity categories to formalize in the regulations.

Kate Burch, of the California LGBT Health and Human Services Network, echoed Ms. Mikalson's statements. The sexual orientation and gender identity questions are not inclusive of the wide range of people and are moving backwards from the best practices on how these questions should be asked. She suggested staff meet with subject matter experts about what these questions should look like.

Stacie Hiramoto, the Director of the REMHDCO, echoed previous speakers' comments in support of the disaggregation of data, and thanked staff for going above and beyond to get this right for everyone. She stated Section 3750(h)(3)(A), measuring the timeliness of care, particularly for underserved communities, is a core component of an outcomes-based approach that embeds reducing disparities in the framework of the MHSA. However, current methods for measuring improved timely access for underserved populations are a concern. The method for collecting data can directly impact the quality of data to be interpreted for measuring outcomes. For this reason, the REMHDCO does not support tracking timeliness of care for underserved populations through measuring tools such as the DHCS external review organization standards, which are not reliable. She encouraged the Commission to show leadership in the disaggregation of data and showing what categories there should be.

Tahira Cunningham, of the California Pan-Ethnic Health Network (CPEHN), echoed the comments of the previous speakers.

Steve Leoni, consumer and advocate, thanked the Commission for disaggregating data, but pointed out that this brings with it a new burden of inclusiveness. He suggested rewording the Asian Indian/South Asian category, in Section 3560.010(b)(5), because people from Pakistan may be upset with that category.

Adrienne Shilton, of the California Institute for Behavioral Health Solutions (CIBHS) and the California Behavioral Health Directors Association (CBHDA), suggested changing the due date for the Annual PEI Program Evaluation Reports from the regulations in Section 3560.010 to the FY after the PEI Regulations are finalized. In Section 3560.010(b)(3), the addition of the stand-alone reporting requirement for access and linkage to treatment is duplicative of what counties currently report in their Quality Improvement Plans. In Section 3560.010(5), these categories need to align with what counties report in the Client Services Information Database and in their EHRs. There are currently no data fields in county EHRs to report a number of these categories. Ms. Shilton stated her support for Section 3750(k), the exemption for small counties under 100,000 in population.

Mr. Gilmer stated his support of comments made by Dr. Cheng, Ms. Mikalson, Ms. Hiramoto, and Ms. Cunningham relative to the disaggregation of data and the timeliness of care.

Brian Sala, the Acting Director of the California Research Bureau with the California State Library, suggested also asking for the standard deviation or variance on the distributions in Sections 3560.010(b)(3)(E) and (4)(F), because the utility of "average interval," for analytical purposes, depends on the distribution.

Janet King, of the Native American Health Center, the REMHDCO, and the CMMC, thanked the Commission for caring about this issue and changing the regulations based on stakeholder feedback. She stated it makes a difference in her position as a Natural Helper, one of the terms Mr. Gilmer referred to earlier. She stated it is important to hold that position at the Native American Health Center, and what made that space is having a PEI program. She thanked staff for removing Section 3750(h)(4). It has allowed her to see individuals who would not otherwise engage. PEI is the most promising and most flexible part of the MHSA that allows reduction of disparities.

David Czarnecki echoed all of the previous comments in support of the disaggregation of data and timeliness of care. He agreed that standard deviations should be included when looking at average intervals.

Ms. Florez echoed all of the previous comments in support of the disaggregation of data. She stated there is usually an error margin when collecting data. She suggested letting counties know where the data is available to be corrected if there is an error.

Kyla Adams, of the REMHDCO, stated her support of the disaggregation of data. She suggested including data collection methods on relationship status and religion. She agreed with Ms. Mikalson and Ms. Burch that there could be more inclusive language with sexual orientation and gender identity.

Ms. McShan echoed the comments of Dr. Cheng, Ms. Hiramoto, and Mr. Gilmer on timeliness of care.

Commissioner Discussion:

Vice Chair Pating suggested, as an amendment to the motion, changing the references for due dates to the FY after the PEI Regulations are finalized for consistency.

Commissioner Keith suggested changing “average interval” to “statistical average and standard deviation of the interval” in Sections 3560.010(b)(3)(E) and (4)(F). He suggested adding “how many individuals completed a treatment program during the reporting period” in Sections 3560.010(b)(3)(E) and (4)(D). Counties need to know this data in order to reassess their programs. Adding this language to the regulations will bring the numbers to counties’ attention and cause them to question why individuals do not complete their programs.

Vice Chair Pating agreed that this information is important, but stated his concern that the PEI funds are for access to, not completion of, treatment. For the PEI Regulations, program treatment completion rate is not being measured. That is a different level of accountability in a different section of the regulations.

Chair Van Horn suggested keeping the original motion with the amendment of the due dates. The other suggestions will go to staff for reworking and come back to the Commission in December as potential changes.

Commissioner Poaster asked what would happen if the disaggregation of the data cannot be done because existing data systems will not handle it.

Mr. Yeroshek stated, if the requirements are never there, the system will never be implemented.

Dr. Bradley agreed. Putting this in the regulations means this is a requirement. She agreed with Dr. Lee that the Commission will need to provide the counties with support so they can ultimately do this.

Chair Van Horn agreed that including the requirement puts everyone on notice that it needs to be part of the new data system.

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

The Commission adopts Staff’s suggested Changes to Proposed Prevention and Early Intervention Regulations and the following additional change: Paragraph (A) of subdivision (a) of Section 3560.010: replace the words, “for fiscal year 2015/16” with the words, “immediately following the effective date of this section.”

Motion carried, 9-0

Staff’s Suggested Rejections to Public Comment

Ms. Yeroshek referenced a seventy-two-page document listing the suggestions from public comments that staff rejected.

Commissioner Questions:

Commissioner Miller-Cole asked if staff noticed any patterns in the type of comments received or in the reasons for rejecting comments.

Dr. Lee stated there were passionate, well-reasoned arguments in completely conflicting directions. She stated her concern that many people had the impression that the Commission’s PEI Regulations did not require any outcomes. Staff made several non-substantive changes to clarify that the regulations require consistent program information, which had never been available before, and outcomes for every kind of program with the exception of outreach to potential responders.

She stated there were many comments about the importance of duration of untreated mental illness, which fell into two categories: those who were not focused on the measurement of duration of untreated mental illness, but were concerned about the efforts to reduce that duration; and those who focused on the consequences of delayed entry into treatment and the desire to ensure that was addressed and measured, whereas counties stated it would be burdensome to measure and it would not be useful.

Dr. Lee stated there were many comments about the critical importance of measuring outcomes and various challenges related to this. There were comments about the value of consistency with current reporting systems. There were many concerns about the critical importance of PEI for diverse communities.

Vice Chair Pating stated he spoke to staff, the CBHDA, and advocacy organizations around the issue of untreated mental illness. Everyone believed there is a need to measure progress with this issue; however, there was concern about how Section 3750(g)(3)(A) will be measured. The National Quality Forum, which oversees the implementation of all national measures, would never put a measure into regulations that has not been piloted or tested. Staff and counties are concerned that there is no definite, tried system of measurement for untreated mental illness, including onset. He stated his concern that the regulations will not only produce bad data but will be unable to show improvement because they ask the wrong question.

Vice Chair Pating recommended making a motion that “the Commission adopts staff’s rejections of public comments to Proposed Prevention and Early Intervention Regulations Sections 3560, 3560.010, 3560.020, and 3750, with the exception of comments 4.03, which is on page 47 of the matrix, which relates to the measurement of the duration of untreated mental illness set forth in Section 3750(g)(3)(A).”

Vice Chair Pating also suggested deleting the language of how untreated mental illness is measured. He suggested convening a work group with counties and advocates to develop a measure for untreated mental illness for the possibility of including it in Section 3750(g)(3) by January of 2015.

Commissioner Keith asked, with that section as it is, if it was possible to define the process by which it is to be measured in technical assistance work with the counties for a consistent way of measuring without having to modify the proposal.

Dr. Lee stated that is staff’s current recommendation.

Commissioner Miller-Cole asked why the measurement for untreated mental illness needs to be in the regulations instead of being accomplished through the work group and translated into the technical assistance process between the Commission and the counties.

Vice Chair Pating stated the CBHDA and the CMHPC claim that most counties do not feel this could be done accurately or well in their current system. The current way it is defined in regulations is not meeting their needs. The Commission needs to look at the specifics of what is not working in the current definition. Once it is put into regulations, the language used must be operational and implementable.

Commissioner Miller-Cole agreed with not putting a bad measure in the regulations, but asked if it could be left with a mandate to track duration of untreated mental illness without a definition.

Ms. Yeroshek stated the problem is that the Office of Administrative Law (OAL) will look at clarity of these regulations. If a word is not defined, it will be bounced back. This is the reason for the definition of the word “program.”

Public Comment:

Ms. Reynoso stated her support of retaining the existing language with no change in Section 3750(g)(3)(A), the duration of untreated mental illness.

Mr. Leoni suggested including the term “Middle Eastern” in Section 3560.010(b)(5).

Ms. Shilton stated her support of the motion to eliminate Section 3750(g)(3)(A) and substitute the time-limited work group to focus on methodology.

Ms. Hiramoto spoke against the motion. She stated the language should remain, partly because it speaks to the trust between the community, the county, and the Commission. If there is to be a work group, she asked that there be no private meetings between the Commission and the counties where consumers, family members, and people from underserved communities are left out.

Mr. Gilmer stated he supported Ms. Hiramoto’s comments.

Commissioner Discussion:

Commissioner Nelson asked if the work group will meet in open meeting.

Chair Van Horn stated the work group will be done under Bagley-Keene. He stated he will appoint the work group. It will include Commissioners, county people, and stakeholders. It will be intentionally small but will be open to the public.

Commissioner Buck stated the need to determine whether the early intervention programs are making a difference. For years, the National Institute of Mental Health (NIMH) has claimed that schizophrenia remains untreated for a period of about seven years. It is imperative to gather data. As imprecise as it is, it is correlation data that will show that there have been important, valuable changes in the future.

Vice Chair Pating stated a bad measure showing no improvement would put the Commission, PEI, and prevention at risk. He recommended finding a measure that everyone agrees is reasonable and will have a chance of an outcome that everyone can trust in.

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

The Commission adopts Staff's rejections of public comments to Proposed Prevention and Early Intervention Regulations Sections 3560, 3560.010, 3560.020, and 3750 as set forth in the, "Matrix of Public Comments with Staff's Suggested Responses" except as to Comments 4.03 et al on page 47 of the Matrix. The Commission deletes the language of how to measure "Duration of untreated mental illness" as set forth in paragraph (A) of subdivision (g) of section 3750.

The Commission will immediately convene a Workgroup to develop a recommendation to the Commission on how to measure the duration of untreated mental illness for the purpose of including it in subdivision (g) of section 3750. The Workgroup will provide its recommendation to the Commission no later than at the January 2015 MHSOAC meeting.

Motion carried, 9-0

GENERAL PUBLIC COMMENT

Ms. Florez thanked the Commission for its work. She stated the Commission is a central point of contact to address concerns in the mental health area. She also stated it should be called "mental health," not "mental illness," because stigma comes with that language. She encouraged the Commission to invite judges to meetings and to have one representative from each of the five areas of law to report back to the court system, because they affect the humans that go before them. Primarily in the juvenile court, there is ignorance about mental health.

ACTION

5A: Proposed Innovation Regulations: Responses to Public Comment

Presenters:

Filomena Yeroshek, MHSOAC Chief Counsel

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist

Ms. Yeroshek provided a brief background, an overview of next steps, and a summary of the suggested changes to the Innovation Regulations.

Staff's Suggested Changes

Dr. Lee reviewed a document titled, "Proposed Changes Presented at the October 23, 2014, MHSOAC Meeting." She stated most of the changes are non-substantive. She went through the document, pointed out each change, and stated the reason for that change.

Public Comment:

Ms. Mikalson stated her appreciation that staff took her comments into account and commended them for adding disaggregation of data for race and ethnicity. Identity is important for many reasons; therefore, what and how to ask for sexual orientation and gender identity and how to concretize it in regulations requires discussion. She stated her belief that this decision requires in-person discussion

between staff and subject matter experts before it is put into writing. She stated as an example that the term “other” is stigmatizing. She stated her concern about the “declined to state” option.

Vice Chair Pating asked Ms. Mikalson to submit her suggestions in writing during the fifteen-day comment period.

Mr. Leoni stated he was part of the planning process and staff accepted most of his suggestions, but noted that the process may have inadvertently led to a further change by the scrutiny that was given. He referenced Section 3910.020(b)(1)(A), about the “continuity of services.” The words “or families” have been crossed out. He stated he understands the logic behind this, but services to families are services also to the consumer through the family. Mr. Leoni suggested finding an alternative to “continuity of services,” and stated his hope that it would be a transition to something that would include families, particularly if it helps the consumer.

Ms. Burch echoed Ms. Mikalson’s comments. She emphasized asking these questions correctly and in a culturally-competent manner. She agreed with having a discussion on what these questions should look like. Since these are in two sets of regulations, it is important to ask the questions consistently. To have them identical in both regulations is the way to go as long as they are the correct questions.

Vice Chair Pating asked Ms. Burch to submit her suggestions in writing during the fifteen-day comment period.

Ms. Shilton stated Section 3580.010 categories do not align with what counties currently have to report in the CSI database. These requirements are difficult for counties to meet with their current IT systems and county EHRs. She thanked staff for the change in Section 3910(b).

Mr. Czarnecki agreed with Mr. Leoni. He stated he represents 19,000 consumers and family members in the state of California. He stated the hope that there will be a time when they will be penciled in rather than penciled out. He asked for clarification on Section 3915(b) and the words “risk or onset.”

Dr. Lee agreed that the word use is not ideal and should be changed. The point was that it is linked to the trajectory of mental illness - to ensure innovation, like PEI and CSS, is linked to the risk or onset or recovery from mental illness without losing that core MHSA purpose. The intention was to say whatever the evaluation is measuring ultimately relates back to that broader MHSA purpose, which is to improve mental illness at whatever stage it is in and the system broadly defined that treats it.

Ms. Yeroshek suggested that this comment be submitted during the fifteen-day public comment period.

Commissioner Miller-Cole agreed with the importance of getting the language correct, given the importance of the regulations, and giving staff a chance to wordsmith it.

Commissioner Nelson asked, if Section 3910.020(b)(1)(A) strikes out “or families,” where families fit in.

Dr. Lee stated it is clear that innovative projects include families. What is in question is, when an innovative project ends, what the responsibility is to provide transition, care, and continuity for individuals who are served by programs. One could argue that counties should provide continuity for everyone who is being served, but an innovation program is by definition a time-limited and unique program, so it is not possible to refer anyone to a comparable program. Staff decided the correct balance was to ensure that every county had a plan and reported on it to provide continuity for people with serious mental illness who were being served by the program, but it was not required for family members or people in prevention programs who were at risk.

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

The MHSOAC adopts staff’s suggested changes to Proposed Innovation Regulations.

Motion carried, 8-0

Staff's Suggested Rejections to Public Comment

Ms. Yeroshek referenced a nineteen-page document listing the suggestions from public comments that staff rejected.

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

The MHSOAC adopts staff's rejections of public comments to Proposed Innovation Regulations as set forth in the "Matrix of Public Comments with Staff's Suggested Responses."

Motion carried, 8-0

ACTION

6A: Client and Family Leadership Committee (CFLC): Approve Letter to the California Mental Health Planning Council to Support Peer Certification

Presenters:

Ralph E. Nelson, Jr. M.D., MHSOAC Commissioners, CFLC Chair
Tina Wooton, MHSOAC Commissioner, CFLC Vice Chair

Commissioner Nelson stated - the CFLC is asking the Commission to support and help institute peer certification in the state of California by sending a letter to the CMHPC supporting their efforts to bring peer certification to the state of California.

Commissioner Wooton reviewed the CMHPC efforts for peer certification, defined what a peer specialist is, provided support for using peer specialists, listed the findings from community forums regarding peer services, and promoted peer certification in the development of the 2015 Work Plan.

Commissioner Nelson stated this issue has been in progress for five years. He stated the hope that this letter will help move these agencies forward instead of waiting for someone else to do it.

Public Comment:

Ms. Hiramoto stated the REMHDCO supports this in general, but she asked the Commission to seriously consider expanding the definition of the term "peer," which should include people with lived experience in racial or ethnic underserved communities who do not often identify with the terms "consumer," "client," or even "family member." She stated the need for services and relationships with underserved communities to avoid perpetuating disparities. The current mainstream peer, client, and family organizations do not often connect with communities of color or racial and ethnic communities. She noted that the CMHPC does not have a cultural competence committee nor do they have many people connected to underserved communities. She stated the hope that the Commission would consider inviting representatives to speak for communities.

Mr. Gilmer stated his support of this initiative. He stated he has attended several meetings in the past to talk about expanding peer terminology. Transformative strategies from a racial and ethnic perspective should be more inclusive following the CRDP reports, terms, and definitions. Cultural brokers, cultural ambassadors, promoters, pastoral counselors, lay counselors, lay ministers, parish nurses, and natural helpers function like a peer but, implemented in communities, are very different than peer methodology. A certification program, like a peer program, should include cultural issues and social determinants of health in a training program that is conducive to and congruent with underserved communities. He asked the Commission to broaden the definition of "peer" and to involve underserved communities in the process so that all people can be helped.

Mr. Leoni stated the CMHPC is not initiating or developing anything and the wording of the letter is a problem. The CMHPC is working with what Jane Adcock refers to as "the group of committed individuals." There are sensitivities in these communities about not being co-opted. He suggested a couple of minor changes to keep the faith and keep the peace with these vital people. In the second paragraph of the letter, he suggested changing "your intent to develop a road map" to "your intent to support stakeholders as they develop a road map," and changing that the Commission applauds the CMHPC "for initiating this process" to "for assisting the stakeholders in this process." In the last paragraph on page one, he suggested changing "the Planning Council's process" to "this important process."

Mr. Leoni described the alarm of the stakeholder community when they thought the CMHPC was taking this over. However, the CMHPC assured stakeholders that they are not taking over but are asking stakeholders to take the lead.

Commissioner Questions and Discussion:

Vice Chair Pating asked staff to read a previously-adopted policy paper. He noted the paper does not have a specific policy on peer certification, but there are two related policy issues on employment.

Interim Executive Director Gauger read two goals related to employment of client and family members in the May 2011 CFLC policy paper titled, "Client-Driven, Family-focused Transformation of the Mental Health System through the MHSA."

Vice Chair Pating stated the Commission is on good ground with regard to previous policy in supporting peer certification. He asked Commissioners Nelson and Wooton if they wished to make any changes to the letter based on the requests during public comment.

Commissioner Nelson stated the World Wellness Group (WWG) was funded by the Office of Statewide Planning and Development (OSHPD) to provide an outline of things that need to be done. Approximately \$8 million to \$10 million was given to the OSHPD for development of education and supported employment, but, so far, none of it is being used for peer certification. They do not have the authority because Agency has not approved anything for peer certification. At present, no one is taking responsibility to push peer certification forward. At the last CFLC meeting, Jane Adcock said Senator Beall's assistant, Sunshine Borelli, talked to them about what would be needed for legislation. The one agency that has done something is the CMHPC. He stated it would be helpful for Commission staff to confer with Ms. Adcock.

Commissioner Wooton stated they are here to ask for promotion of the letter to go to the CMHPC in support of the efforts that the CMHPC is doing. She proposed some next steps that the CMHPC or the Commission could do to try to get Agency, the DHCS, the OSHPD, and the CMHPC together as another friendly amendment to this motion. Staff and the CFLC have been very involved.

Commissioner Poaster asked if there was anything with regard to this in the five-year Workforce, Training, and Education (WET) plan that was recently adopted.

Commissioner Wooton stated they are supportive of peer certification, but there are no dollars attached to it.

Commissioner Nelson agreed that everyone supports peer certification but no one wants to do anything about it.

Vice Chair Pating stated the motion to approve the letter as it is with a secondary request that staff will work with the CFLC to encourage the convening of interested groups as a next step.

Commissioner Wooton assured members of the public that the involvement of multi-cultural persons is already a Commission policy. She stated the hope that all communities will be involved as this moves forward.

Action: Commissioner Nelson made a motion, seconded by Commissioner Wooton, that:

The Commission endorses the letter of support to the California Mental Health Planning Council regarding Peer Certification efforts and to send a copy of the letter to California State Senator Jim Beall, Sunshine Borelli, Deputy Chief of Staff for Senator Jim Beall, and Kiyomi Burchill, Health and Human Services Agency, Assistant Secretary, Office of Program and Fiscal Affairs..

Motion carried, 8-0

ACTION

7A: Evaluation Committee: Approve Older Adults Evaluation Scope of Work

Presenter:

Renay Bradley, Ph.D., MHSOAC Director of Research and Evaluation

Dr. Bradley stated this was an evaluation activity that was prioritized to be completed this current FY. She presented the scope of work that was generated for this project. She reviewed the background, goals, scope of work, and next steps for this project.

Commissioner Questions and Discussion:

Commissioner Poaster asked about the amount of MHSOAC funds being used for older adults.

Dr. Bradley stated, in looking at funding for current evaluations, sometimes MHSOAC dollars are specified, and other times counties are asked to provide whatever funds they are using so that it can be broadened.

Commissioner Poaster stated it would be useful to be able to talk of programs developed through MHSOAC dollars for older adults.

Dr. Bradley stated "Prop 63 and other public funds" is in the scope of work; it was the intention to go the broader route.

Vice Chair Pating suggested considering this for younger adult services if the information helps the Finance Committee assess the work.

Commissioner Poaster stated a great percentage of services for older adults in the last three or four years have been developed because of the MHSOAC. There is little funding elsewhere.

Dr. Bradley stated they are currently doing a project with transition-age youth (TAY) with a similar scope of work. They are looking at funding mechanisms including MHSOAC and other public sources.

Vice Chair Pating stated the need for comparable data across studies.

Commissioner Miller-Cole asked how stakeholder feedback about reducing disparities will be translated into this Request for Proposal (RFP).

Dr. Bradley stated, when entering into a contract like this, there is a contractual obligation that evaluations and assessments will look for differences across demographic groups, to the extent that the data is available. Currently-existing data collection systems have been problematic. In something like this, counties would need to contribute information about the extent to which they are implementing programs for older adults.

Action: Commissioner Keith made a motion, seconded by Commissioner Poaster, to:

Authorize the MHSOAC Interim Executive Director to initiate a competitive bid process requesting proposals to evaluate progress made in implementing an effective system of care for older adults with serious mental illness in order to identify methods to further statewide progress in this area.

Motion carried, 7-0

GENERAL PUBLIC COMMENT

Mr. Helmick stated the REMHDCO will hold a reception on November 6, 2014, in Ventura County, along with the African American SPW immediately following the MHSOAC Community Forum.

Vice Chair Pating suggested emailing the handout to Commissioners.

ADJOURN

There being no further business, the meeting was adjourned at 3:08 p.m.