



State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
October 22, 2015

Fess Parker Hotel
Santa Ynez Room
633 East Cabrillo Boulevard
Santa Barbara, California 93103

866-817-6550; Code 3190377

Members Participating

Victor Carrion, M.D., Chair
John Buck, Vice Chair
Khatera Aslami-Tamplen
Sheriff William Brown
Paul Keith, M.D.
Ralph Nelson, Jr., M.D.
Larry Poaster, Ph.D.
Richard Van Horn
Tina Wooton

Members Absent

Senator John Beall
John Boyd, Psy.D.
David Gordon
Assemblymember Tony Thurmond

Staff Present

Toby Ewing, Ph.D., Executive Director
Brian Sala, Ph.D, Deputy Director,
Evaluation and Program Operations
Norma Pate, Deputy Director,
Program, Legislation, and Technology
Filomena Yeroshek, Chief Counsel
Pete Best, Staff Services Manager
Deborah Lee, Ph.D., Consulting Psychologist
Sheridan Merritt, Research Program
Specialist
Cody Scott, Staff Services Analyst
Moshe Swearingen, Office Technician

CONVENE

Chairman Victor Carrion called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:09 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and announced that a quorum was present.

Announcements

Chair Carrion announced that Deborah Lee, Ph.D., Consulting Psychologist to the Commission, is retiring and that this is Dr. Lee's last Commission meeting as she will be retiring on December 30th. He thanked her on behalf of the Commission for her work, expertise, teaching, and dedication during her years of service and wished her well.

ACTION

1A: Approve Meeting Minutes from the September 24, 2015 Commission Meeting

Action: Vice Chair Buck made a motion, seconded by Commissioner Nelson, that:

The Commission approves the September 24, 2015, Meeting Minutes.

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vice-Chair Buck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Keith	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Miller-Cole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Nelson	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Commissioner Thurmond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Van Horn	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFORMATIONAL

1B: September 24, 2015, Motions Summary

1C: Evaluation Dashboard

1D: Plan Review Dashboard

1E: Calendar

ACTION

2A: Elect Chair and Vice Chair for 2015

Presenter:

Filomena Yeroshek, Chief Counsel

Ms. Yeroshek briefly outlined the election process and asked for nominations for chair of the Commission for 2016.

Action: Commissioner Poaster made a motion, seconded by Commissioner Van Horn, that:

The Commission elects Victor Carrion as chair for 2016.

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vice-Chair Buck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Keith	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Miller-Cole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Nelson	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Poaster	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Thurmond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Van Horn	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ms. Yeroshek asked for nominations for vice chair of the MHSOAC for 2016.

Commissioner Aslami-Tamplen was nominated for vice chair by Commissioner Van Horn and seconded by Commissioner Poaster. Commissioner Aslami-Tamplen declined the nomination.

Action: Commissioner Aslami-Tamplen made a motion, seconded by Vice Chair Buck, that:
The Commission elects Tina Wooton as Vice Chair for 2016.

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vice-Chair Buck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Keith	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Miller-Cole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Nelson	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Poaster	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Thurmond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Van Horn	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFORMATIONAL

3A: Improving Crisis Services for California’s Children and Youth – Panel Presentations

Facilitator: Toby Ewing, Ph.D., Executive Director

Dr. Ewing introduced the members of the panel for today’s panel discussion, a continuation in the series of discussions on crisis services as a part of the continuum of care in mental health.

Panel 1: Setting the Agenda – Crisis Service Providers

Crisis service providers will discuss the challenges and importance of delivering effective mental health crisis services for children and youth.

- **Lyn Morris, MFT, Senior Vice President, Clinical Operations, Didi Hirsch Mental Health Services**
- **David Ketelaar, M.D., Emergency Medicine, Dignity Health**
- **Sarah Adams, LCSW, Program Manager, Casa Pacifica, Safe Alternatives for Treating Youth (SAFTY)**

Lyn Morris

Lyn Morris, MFT, Senior Vice President, Clinical Operations, Didi Hirsch Mental Health Services, stated that Didi Hirsch is a large mental health center on the west side of Los Angeles, providing mental health and substance use services from birth to older adults and is home of the nationally-recognized Suicide Prevention Center (SPC). The SPC

operates a 24/7 Suicide Prevention Crisis Line, which also covers a teen crisis line for 20 hours per day.

Ms. Morris spoke about the rise in suicide rates – the worst-case scenario being when children’s mental health needs are unmet – and the misconception that speaking about suicide causes suicide when, in reality, raising awareness and erasing the stigma around suicide can address this issue.

Ms. Morris reviewed the statistics from the American Association of Suicidology data and shared personal experiences in suicide prevention for children. She stated that children are dying out there because there are not enough resources. She stated that the SPC provides teen chat services eight hours per day. They receive 20,000 chats per month, but they can only answer 7,000 of them due to lack of resources. She asked what happens to the 13,000 children who are reaching out when services are not there.

Ms. Morris stated that she supports the important work of improving the California system to help children and youth.

David Ketelaar

David Ketelaar, M.D., Emergency Medicine Physician, Marian Regional Medical Center (MRMC), Santa Maria, stated that the Commission sees mental health services for children and adults at the middle and back ends while he sees it at the front end. He stated that the front end is extremely frustrating. He provided examples to increase awareness of what is happening at the front end today.

The MRMC has a 32-bed emergency department (ED). He stated that children brought in on 5150 holds are languishing while waiting, often 30 to 39 hours, for a bed and the care they deserve. He stated that this is occurring daily in EDs statewide. He stated that he feels horrendous for not being able to provide the level of care to these patients that is provided to other medical patients. Medical emergencies are whisked away immediately to the necessary medical facility to best treat them, but patients with mental health emergencies are left for hours and days while doctors call all over the state to search for an available bed for them; many times, there are no beds available for them. Oftentimes, the safety staff does a commendable job of putting together services for these patients, but it is not doing the acute crises intervention that is necessary. Many facilities have the necessary interventions, but do not have the capacity.

Dr. Ketelaar stated that many patients do not need long-term stays, but acute crisis stabilization that occurs over 12 to 24 hours. If those services can be provided up front, many times the need for the 72-hour or longer stay is negated, but EDs across the country are not equipped to provide the services. This segment of the population needs some advocacy.

Sarah Adams

Sarah Adams, LCSW, Program Manager, Safe Alternatives for Treating Youth (SAFTY), the mobile crisis team in Santa Barbara County operated by Casa Pacifica that also runs a mobile crisis team for children in Ventura County, spoke next. Casa Pacifica has been operating both crisis hotlines for ten years.

Ms. Adams stated that she agreed with her fellow panel members about the statistics and the lack of available bed space. She spoke about other challenges seen in the field as a mobile crisis team member. She stated that what is lacking is a continuum of crisis services. The mobile team tries to keep children in the home or with other family members in the community and to use natural resources as much as possible.

Ms. Adams stated that, oftentimes, children do not meet the legal criteria for a 5150 or 5585, but providers or law enforcement do not feel comfortable leaving them at home – there is a gray area. SAFTY provides 24-hour follow-ups, phone check-ins every 15 minutes or every hour, and revisits for reassessments when necessary. However, there is a gap where a 23-hour bed, a stabilization unit, or other intensive treatment to provide immediate crisis care would help solve the issue and give the family and the child some respite. She stated that, oftentimes, the crisis is resolved within that 12-to 24-hour period.

The crisis lines are understaffed at seven staff each for Santa Barbara and Ventura Counties. Both teams have one person on call at a time who sometimes works double shifts. Staff wellness support is also important; burnout is common. Ms. Adams suggested better pay for staff, additional on-call stipends, and additional safety stipends in the field may help. It would also help for staff to have assistance in linking families to ongoing services.

Commissioner Questions and Discussion:

Chair Carrion stated that integration is critical. He asked if there were programs or centers that integrate primary care and mental health. Ms. Adams said there were a few in Santa Barbara, such as the Neighborhood Clinics in Santa Barbara, and Clinicas in Ventura County.

Commissioner Keith asked if part of the difficulty of getting a child to a hospital was the kind of insurance or noninsurance they have. Dr. Ketelaar stated that insurance is always an issue.

Commissioner Keith asked if there was capacity in the ED to get a mental health professional or social worker to do a psychiatric assessment to help determine the level of care needed. Dr. Ketelaar stated that his hospital has internal programs in place such as paying a psychiatrist separately to address the issues, but much more is necessary. His team is not a crisis stabilization unit; they are a medical stabilization unit.

Commissioner Nelson asked if patients' medications are continued while in the ED. Dr. Ketelaar stated that medications are continued, and ED doctors use their own expertise and consult with the psychiatrist, clinics, and laboratories on any additional medications that may be necessary.

Commissioner Nelson asked if crisis workers and ED doctors use patients' electronic health records (EHRs) in cases where the patient is 5150ed. Dr. Ketelaar stated they do if the records are available, but oftentimes the data systems are not compatible.

Ms. Morris stated that they have a database for callers.

Ms. Adams stated that crisis teams in the field have access to EHRs, but they do not communicate with the medical EHRs.

Commissioner Nelson asked if the medication information on the EHRs is shared with ED personnel. Ms. Adams stated that EHRs may be available if the patient is a county mental health patient. If they have a private clinician, those records may not be available.

Commissioner Nelson shared an experience of a patient who was 5150ed and sat in the ED for four days without any medications. By the time he was sent to the hospital, he experienced a set-back because of it. Dr. Ketelaar stated that, many times, EDs don't do a good job of keeping up on medication. There is room for improvement in this area.

Vice Chair Buck stated that this is a complicated issue and that liability issues make it more so. Senate Bill (SB) 82 tried to address the overcrowded ED issue by creating 2,000 residential beds within six months, but barriers are huge to even getting one program going. He stated that he appreciated the members of the panel raising the flags and calling it to the Commission's attention.

Commissioner Brown stated that the Commission recognizes that the members of the panel are under-resourced and over-extended. There is concern about the lack of psychiatric emergency beds available throughout the state, and the problem is particularly acute with juveniles. It is more cost-effective to expand existing psychiatric health facilities than to build individual 16-bed units. He stated that the Commission is cognizant of the problem. The Commission and state, federal, and local governments should all be pushing for a change in the restrictive 16-bed regulation.

Panel 2: Why Solve the Problem? – State and Local Government Representatives

Panel members will address the challenges and opportunities of providing effective crisis services to children and youth throughout California.

- **Janet Wolf, President, Santa Barbara County Board of Supervisors**
- **Suzanne Grimesey, MFT, Chief Strategy Officer, Santa Barbara County Alcohol, Drug, and Mental Health Services**
- **Das Williams, California State Assembly Member, 37th District**
- **Steve Bennett, Ventura County Board of Supervisors**

Janet Wolf

Janet Wolf, President, Santa Barbara County Board of Supervisors, stated that the interaction and collaboration between probation and mental health personnel has been remarkable. It is essential that policymakers support innovative, evidence-based programs and collaborations as alternatives to incarceration.

Ms. Wolf stated investing in immediate and triage response to trauma can prevent post-traumatic stress disorder (PTSD), which often leads to greater problems and challenges in life. However, training culturally and linguistically competent staff, educating parents to identify potential crises, and having residential placement available for crisis stabilization all take resources.

Suzanne Grimesey

Suzanne Grimesey, MFT, Chief Strategy Officer, Santa Barbara County Alcohol, Drug, and Mental Health Services, stated that Santa Barbara has built strong partnerships that have developed programs to individualize services for children and make every effort possible to avoid placements out of county and hospitalizations. However, a robust children's system of care only goes so far without a strong crisis system present to intervene at critical moments for children and families.

Santa Barbara's SAFTY Mobile Crisis Response Program for Children and Families provides mobile crisis response; develops proactive crisis plans before a crisis occurs; continues to provide support to families after a crisis; and develops plans for when children return to the community from out-of-home placement or hospitalization.

Current challenges:

- No local in-patient acute psychiatric beds for children and adolescents
- No crisis stabilization beds for children and adolescents in the community
- No resident day treatment within the community
- Inadequate funding to provide robust staffing and the same mobile crisis, proactive follow-up and linkage services for uninsured families

Additional funding could allow for expanded, intensive in-home services, crisis stabilization beds in the community, and more proactive crisis response.

Das Williams

Das Williams, California State Assembly Member, 37th District, stated that children lack access to the entire continuum of care, both locally and statewide. Services exist but are in short supply, and crisis beds do not exist in most counties. There is no code under Medi-Cal, so there is no funding stream to cover it.

Steve Bennett

Steve Bennett, Ventura County Board of Supervisors, stated that the best investment to make for children in crisis is crisis services. Bed boarding in ER is not acceptable and would not be accepted if it was a medical crisis. Mr. Bennett asked for help from the Commission regarding two local challenges: local opposition to a crisis stabilization facility and the not in my back yard issue and ambulances not arriving in as timely a manner for a mental health crisis situation as they would for a medical crisis situation like a heart attack. When crisis team call of an ambulance it can be an eight (8) hour wait. He asked the Commission to help with these issues.

Mr. Bennett stated that the tensions between the police and the behavioral health department in Santa Barbara have lessened as they have worked together, which improves coordination in crisis situations. Keeping children local allows their families to support them and is a more efficient use of funding.

Commissioner Questions and Discussion:

Vice Chair Buck stated that he agreed with the need for political will to allow crisis services in neighborhoods. He stated his appreciation that the panel members'

organizations are preparing for when the opportunity or resources arrive. He encouraged them to continue to prepare and unify with partners and colleagues to be in a position to reduce the resistance to putting services in the community.

Commissioner Brown stated the importance of having elected officials with an understanding of the benefits of services for the community and experienced partnerships with community-based organizations and nonprofits. It is also important for the Commission to encourage open-mindedness when the types of services that the Commission supports are proposed in communities across the state.

Commissioner Aslami-Tamplen stated that children are best served in their own homes with their families. She suggested focusing on parent partners who have been through the system and want to reach out to others to help them understand options that are not dependent on the system. She also suggested focusing on youth advocates. Talk therapy can be as supportive and effective as medication.

Commissioner Van Horn stated that Medicaid is an entitlement that requires a state share. The provider rates are under government control. Assembly Member Williams stated that the issue is raising provider reimbursement rates. There is not enough money in the system to make it work how it should without taking funding from other programs. A dedicated tax is the only realistic way to make the Medi-Cal system work in the long run. He stated the federal match is about to expire.

Commissioner Wooton stated the need for paraprofessionals, youth and family advocates, and parent partners in the system.

Commissioner Keith stated the need to look at the quality of care provided to children and adolescents in residential care. He suggested quality assessment of residential programs.

Panel 3: How Can We Solve This? – State and Local Leaders in Crisis Services for Children and Youth

Panel members will discuss exemplary mental health crisis programs and service delivery models for children and youth.

- **Jody Kussin, Ph.D., Director of Community Programs, Casa Pacifica Center for Children and Families**
- **Debbie Innes-Gomberg, Ph.D., Department of Mental Health, County of Los Angeles**
- **Rusty Selix, Executive Director, California Council of Community Behavioral Health Agencies**

Jody Kussin

Jody Kussin, Ph.D., Director of Community Programs, Casa Pacifica Center for Children and Families, stated that suicide, on a larger level, is hard to fathom as individuals, parents, community members, and mental health professionals. Part of the solution is to identify and acknowledge the problem and talk about it; already, movement is being made in the right direction. There is a gap between what has been learned from research and science and what is provided in service delivery. Peer support is critical. The long-term impact of children spending time in an in-patient psychiatric facility does

not have positive outcomes, but intensive, in-home services are what work and are cost-effective.

The problems:

- There are not enough beds in California
- Beds cannot be identified across the state except by calling individual facilities
- Youth must be shipped to these facilities, away from families for 72 hours

The solutions:

- To increase resources to provide intensive, in-home-based services
- To integrate research and science
- To look at things from three perspectives:
 - Prevention and early intervention (PEI) – includes simple, inexpensive things such as placing billboards in strategic locations and providing social media outlets to proactively serve individuals in crisis
 - Intervention – includes providing increased stability, intensive in-home services, and peer support
 - Postvention – includes grief counseling and linkage to services to those affected, including local health professionals and law enforcement officers who are in the field

Debbie Innes-Gomberg

Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes District Chief, Department of Mental Health, County of Los Angeles, stated that, in order to address crisis, the service continuum needs to be considered. The Mental Health Services Act (MHSA) provides a framework to plug services into and to address crisis services. The service continuum helps to assess investments in the levels of care. Care coordination and liaisons to the community are critical, but it is a continued struggle to fund those adequately in terms of reimbursement.

Dr. Innes-Gomberg showed a PowerPoint presentation representing Los Angeles County's Continuum of Care System:

- PEI – the more that evidence-based practices are implemented and the impact they have on children is assessed, the more trauma and crises will be impacted.
- Transition – transitioning patients from institutions and diverting them from hospitals to intensive, community supports, including full service partnership (FSP) programs are critical to reducing the likelihood of crisis.
- Wellness, self-help, and peer-support services.

Dr. Innes-Gomberg discussed the evolution of the service continuum, the balance that needs to be achieved, the infrastructure to support the service continuum, the role of the MHSA innovation in informing all of this work, and the measurement of the success of the impact. The investments in extensive diversion programs, programs that help keep

individuals out of hospitals, and programs addressing super-utilizers need to be balanced with PEI. It is important to consider how staff is trained to do this work.

Dr. Innes-Gomberg stated that payment reform, creating a political will for communities to support this work, and outreach, engagement, and education to communities and to the system of care will be particularly important.

Rusty Selix

Rusty Selix, Executive Director, California Council of Community Behavioral Health Agencies (CCCBHA), stated he will discuss what to do with the information presented in these three panels and where to go from here. He stated that the last two Commission meetings and the workgroup meeting discussions are the beginning of a paradigm shift that began with SB 82, through AB 741, and letters from advocates talking about the need for a new approach.

Mr. Selix stated that it is time for an alternative system of crisis response to begin for youth. The old system of long waits in EDs is no longer acceptable. The old solution of having more hospital beds is also unacceptable and clearly violates the federal court case known as Olmstead, which states that individuals must be treated in the least restrictive facility.

The US Justice Department has gone further to say that, if a state or local government invests in hospital care, but then says there is not enough money for less restrictive non-hospital care, it is an explicit violation of the law. Mr. Selix stated the need to build a non-hospital crisis system first and then consider where additional beds may be needed. There are examples of these systems, from Massachusetts and Washington, that show that individuals are more likely to recover more fully, more quickly, and more cost effectively in non-hospital conditions.

Mr. Selix stated that the first item of importance is to consider Medi-Cal, the health plan for half of all youth in California. Crisis services are now fully covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The Department of Health Care Services (DHCS) has said that EPSDT has the first call of growth on the 2011 Realignment funds. Counties have just received their share of the \$60 million of growth from 2013-14. There is another \$150 million of growth from 2014-15 to be allocated so that counties will have the funding, but it is not enough to establish crisis services in all counties.

Mr. Selix stated that the place to start is for counties to begin establishing contracts with providers to offer in-home crisis support, mobile outreach, crisis residential, and crisis stabilization for youth as a basic new component of the continuum of care. The goal is for all parties of the 9-1-1 system to know that this crisis system is in place and adequately funded and staffed in order to serve everyone in this model.

Mr. Selix used Phoenix, Arizona, as an example. Adults with a psychiatric crisis first go to the crisis stabilization unit; from there, some go to crisis residential, some go home, and less than a third go to the hospital if there is a bed available. He stated that, for youth, it appears that part of the adult system is not needed, but that in-home support and doing the necessary outreach is the main model for youth.

Mr. Selix stated that there is already a network of service providers who have the skills. If these providers do wraparound or residential care for youth, they can provide the customized response that youth in crisis need. The challenge is that counties have to provide the funding and the 9-1-1 system, and other parts of the crisis care system must be aware of these services to know where to refer individuals.

Mr. Selix stated that this will take education and training of counties and related staff and a willingness to do something completely new and different. This is a paradigm shift – the awareness that there are alternatives to the hospital-based approach is fairly new, but now that it is known, it cannot be ignored. It must be acted upon.

Mr. Selix stated that incentivizing crisis services should not be only up to the counties:

- Commercial health insurance companies should be utilizing the county networks. They should be incentivized by holding contracts with the same providers or have memos of understanding (MOUs) with the counties.
- The Legislature could also be instrumental in incentivizing crisis services. Assembly Bill (AB) 741 needs to be enacted or the DHCS needs to act without legislation to create a billing category for youth crisis residential to fill the gap in the rate structure.
- Former Senator Darrell Steinberg has proposed that the Legislature augment SB 82 to create even more incentives to act.
- The DHCS and the Department of Finance could condition receipt of future MHSA or Realignment growth funds by saying only those counties with crisis care systems can share from this piece of the growth funds.

Mr. Selix stated that any crisis is a failure of the PEI system. He suggested that the Commission look at how far PEI programs have come in the six years they have been in place, how much farther they need to go, and what key investments are needed to get them where they need to be.

Mr. Selix stated that it is time for the MHSOAC to put out its own report and provide strong recommendations to state and county officials and others about what needs to be done to fulfill one of the key objectives not just of the MHSA, but also of state and federal Medicaid law, so that everyone knows what they need to do.

Mr. Selix offered to work with the Commission on developing the report. He stated that this report will be on a timely, important subject with many ready readers willing to act on the Commission's recommendations. He thanked the Commission for hosting these panels today. He stated that he always envisioned the Commission going beyond just the direct oversight of the MHSA to tackling important issues in mental health, determining what needs to happen, and spreading the word on what needs to be done to make it happen. Commission could facilitate action through making clear and strong recommendations for action pointing out all of these financing, legal, and system of care elements and produce a report like those of the Little Hoover Commission that states what each entity should do and why.

Commissioner Questions and Discussion:

Commissioner Brown asked why the numbers are going up and ages going down in terms of youth in crisis and at risk of suicide and what can be done better in prevention.

Dr. Innes-Gomberg stated that PEI has only been implemented in most counties for about six years, so it is too early to understand the true impacts of it. She suggested addressing protective factors and looking critically at the Katie A. study for how to reduce risk factors and increase protective factors through available avenues.

Dr. Kussin stated that there is not one profile for what a youth who is suicidal looks like. She stated the need to strengthen the definition of family. Youth who are suicidal tend to feel that they do not belong anywhere and are a burden to someone. The good thing is awareness is increasing through suicide prevention programs. People are reaching out for help, educators and law enforcement are being educated on this issue, and stigma is decreasing as awareness is increasing.

Mr. Selix stated that not enough is known to fully answer this question. Not enough has been invested outside of the mental health system for PEI to get to the missed opportunities. There should be a system in place that provides on-campus help for every youth who has any kind of problem. He recommended further investment in making information available on the Internet.

Commissioner Keith encouraged Dr. Innes-Gomberg to use longer-term measures for functional outcomes to determine the effectiveness of the interventions. He asked if tele-psychiatry is being utilized. Dr. Kussin stated movement is in that direction, but there are not enough child psychiatrists in the state. Psychiatrists are good for assessments, but cannot substitute for in-home intervention.

Commissioner Van Horn stated that he asked in yesterday's meeting if FSPs could be done for children and youth that were home-based. He stated that parent partners can be used in an FSP in ways that are not as expensive as using highly-paid clinicians to fill in the kind of support that the family needs to get better. It is not just about the child, but the family is also in crisis.

Mr. Selix stated that Massachusetts and Washington have shown that EPSDT can pay for those home-based services, so it does not need to be an FSP, although it can function like an FSP.

Dr. Kussin stated that UCLA is preparing a White Paper on this topic that has to do with integration of primary care, home-based services, and how to make this work from a collective prospective.

Dr. Innes-Gomberg stated that Los Angeles, as part of the expansion plan for Community Services and Supports (CSS), is funding Intensive Field Capable Clinical Services (IFCCS) for children, which are similar to FSPs.

Chair Carrion underscored that there is nothing in the literature that says children are resilient. In fact, it is the opposite – children are vulnerable. It is the presence of an adult in a child's life that helps the child process situations.

Public Comment:

Jessica Hall stated that she and her husband pay \$1,000 per month for health insurance for a family of five, not including co-pays and deductibles. She shared her experiences, beginning in 2007, when her then-13-year-old son needed a mental health evaluation at UCLA, of waiting in ERs, of being in and out of hospitals for months, of her son's asking for help at age 17, of the frustration of unavailable services, and then, when a bed was found for him, of the inadequate amount of time given to help him. Ms. Hall said the mental health process is confusing, uninformative, and not understanding. School counseling is inadequate. There are no beds and no funding for crisis residential. Parents need more information.

Ms. Hall asked the Commission to find the funding, inform the parents, find children the appropriate placements, create a support circle for families, let families know how they can help, and attend community events – to make parents accountable so they will rise to the occasion to help mental health services be the best that they can be.

Lori Litel, Executive Director, United Parents, agreed that prevention services and crisis stabilization services should happen in the home to keep children in the least restrictive environment.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that the panel was missing individuals that could speak to the issue of serving underserved racial and ethnic communities. She stated that these experts would inform the Commission of things none of the other panelists would know. She asked that the panels in the future have another voice to tell another perspective. She stated that she appreciated that the panel advocated for PEI, but she cautioned that PEI should not solely be evidence-based practices.

Zima Creason, CEO, Mental Health America of California (MHAC), stated that MHAC works to ensure that everyone who needs mental health services has access to the appropriate services at the appropriate time. She stated the MHAC Youth Empowerment Network has made suicide prevention a focus of their work. She stated the need for crisis care and for before-crisis care before tragedy happens.

Jim Gilmer stated that prevention is the most important element to avoiding crisis. He stated that there will never be enough beds, particularly for youth of color. There needs to be more focus on creating more opportunities for safe places of refuge. He suggested looking at community-defined practices, looking at the front end, broadening the reach, creating other portals of support in the communities that are cost-effective, and doing system transformation of schools.

Steve Leoni, consumer and advocate, stated that the Office of Health Equity has a new pamphlet out on health and mental health in all policies.

Steve Elson, CEO, Casa Pacifica, stated that the crisis mobile response teams in Santa Barbara and Ventura Counties are funded fifty percent by MHSA dollars. He asked where the commercial insurance companies are because these counties are relieving them of their responsibility during these crises. He stated that the counties have tried billing the commercial insurance companies and their response has been that mobile response is a law enforcement function. He asked that the Commission report

this to the Legislature to bring commercial insurance companies to the table to help address this issue. It would free up MHSA dollars to be used more strategically elsewhere.

Mr. Elson stated that the MHSA has historically been rolled out by program. He suggested making a fund within each county to be used on an individual basis as an alternative to expensive programs.

Susan Kelly, Youth and Family Division Manager, Ventura County, stated that Ventura County does not have a continuum of services that supports children in the community. Children are either sent home or to the hospital – there is no other choice. Ventura County has purchased a facility for a crisis stabilization unit and a short-term crisis residential program, which is hoped to be up and running by the first of the year, but it will not be sustainable. She asked the Commission to find creative, reliable ways to fund and sustain these programs, and to find specific ways to use Medi-Cal and EPSDT funds. She stated that private insurance should be responsible for at least one third of the cost, but when billed, they send rejection notices.

Candace Brennan, member, SAFTY Mobile Crisis, Casa Pacifica, shared personal experiences from out in the field. She stated that when kids are in crisis, the team does everything they can to keep them safe, which sometimes means a 5150. If that child does resurface, and they do, she stated that they often ask for another 5150 because they feel they are helped. They have 15-minute room check-ins, group counseling, individual therapy, medical evaluations and support, and access. She stated that the way to solve this problem is to listen and to make these services more available and easily accessible in the home and in the community.

Ted Rodriguez shared the experiences of his 14-year-old daughter, who was suicidal, going to the hospital, of the doctors changing her medication the day before she was released, and of her running away. He asked why his daughter was not allowed to remain under observation with the new medication in the hospital. He told of her being transferred to Northern California though he lives in Southern California and of his daughter asking him to come visit every day, of the hospital calling a week later to say that she would be discharged the next day, and of trying to juggle work and attention to his daughter's needs. He asked the Commission if there were any other hospitals closer to his home where his child could be placed. He praised the SAFTY team for their help. He stated that they call his daughter every night just to see how she is doing.

Chair Carrion asked staff to meet with Mr. Rodriguez to give him information about alternative locations. He stated that Mr. Rodriguez's story brings to light everything being discussed today.

David Deutsch, Executive Director, National Alliance on Mental Illness (NAMI), Ventura County, stated that the Parent and Teachers as Allies program does in-service training where teachers and parents have an opportunity to learn from people whose adolescent family members have lived experience with mental illness and how to identify early symptoms or warning signs. He stated that the Ending the Silence program is for high school students and operated by volunteer students to help identify possible signs. He stated that an answer to the question of why there are rising rates in suicide is that the world is much more complicated. He stated that technology has

provided wonderful things but has had unintended negative consequences. He also stated that evidence-based practices without cultural competency are not evidence-based practices for non-dominant culture members of society.

GENERAL PUBLIC COMMENT

Refugio Rodriguez stated that one of the highest trends is the high incidence of suicide of Latino youth. He stated the need to gather data by ethnicity because all things are not equal among populations in terms of access and interventions. Evidence-based practices are not reflective of Latinos, African Americans, or Asian Americans. It is important to look at other interventions to be effective, especially when dealing with young people in crisis.

Ken Bonar stated the need for young people to get treatment and not to be talked at but to be talked to. He stated that it is time for an action plan.

INFORMATIONAL

Closed Session – Government Code Section 11126(A) related to personnel

The Commission met in closed session as permitted by law to conduct the six-month performance evaluation of the executive director.

INFORMATIONAL

Report Back from Closed Session

Presenter:

Victor Carrion, M.D., Chair of the MHSOAC

Chair Carrion reconvened the meeting and stated the Commission took no action. The Commission agrees with the vision and direction of the executive director.

INFORMATIONAL

4A: Executive Director Report Out

Presenter:

Toby Ewing, Ph.D., MHSOAC Executive Director

Staff Changes/Vacancies:

Dr. Ewing introduced new MHSOAC employees. He also named the employees who will be transitioning on and stated that there will be time set aside in the January agenda to thank Kevin Hoffman, Dr. Deborah Lee, Dr. Renay Bradley, and Jose Oseguera for their contributions.

Budget:

The Legislature augmented the Commission's budget by one million dollars to enhance stakeholder contracts. There will be an update from the Department of Finance in December on revenues. At this time, there is no room in the cap for the one million dollars.

It is possible that not all evaluation contracts will go out by the end of the fiscal year. The Commission is not on track to spend all of the research dollars for this fiscal year and will ask for permission to roll the money over so it will not be lost.

In the December meeting, staff will ask for approval to establish a mental health administration savings fund to allow the Commission to reserve funds that have not been spent for administrative expenses rather than going back into the primary fund.

Former Senator Steinberg and the Steinberg Institute have put together a proposal for some reforms in mental health: a housing bond, additional funding for crisis services augmenting SB 82, and recognizing the need for mental health services on college campuses.

Speaking Engagements:

Commissioner Aslami-Tamplen stated that she attended the National Alternatives Conference, funded by the Substance Abuse Mental Health Services Administration (SAMHSA), the largest conference focused on recovery and care services. She conducted a workshop on the *Choices to Heal* documentary in collaboration with Dr. Ewing and Jennifer Whitney, Director of Communications. She stated that attendees were in awe of what is happening in California and that the documentary highlighted the diversity of the state and how needs are being met.

Dr. Ewing was invited to speak last week at a three-day global conference in Mexico, hosted by the Organisation for Economic Co-operation and Development (OECD), with themes on indicators, outcomes, and knowledge of policy. He stated that the conference included a strong behavioral health and wellness component.

Dr. Ewing has been invited to speak at the Words to Deeds Conference in November. Commissioner Brown is part of the planning group for the conference. Dr. Ewing has also been invited to speak at a California Forensic Mental Health Association meeting about the intersection between mental health and criminal justice and has been asked to support a conversation with Bay Area business leaders about the importance of mental health and mental health investment.

Community Forums:

The next forum is in Fresno in November. The MHSOAC will be conducting focus groups with a Latino farm worker group and with community leaders as an extension of its community forum work.

Stakeholder Contracts:

A facilitator was hired to conduct a three-month process of one-on-one consultations with all contract holders and two large group meetings on lessons learned and opportunities. A report from the facilitator is due in the next few weeks.

Triage:

Pete Best, Staff Services Manager, has taken the lead in shifting the triage conversations with the counties around how to add value. Mr. Best has invited the Department of Health Care Services (DHCS) to provide technical assistance for

Medi-Cal billing. The MHSOAC has begun to leverage and engage counties and counties are happy with what the Commission is doing.

Research and Evaluation:

Dr. Ewing met with Commissioners Poaster and Van Horn to explore potential models for research and evaluation and to find better ways to leverage the Commission's limited funding.

Projects:

The Little Hoover Task Force Project

The Little Hoover Commission paper is still in the writing phase.

Regulation Implementation

Commissioner Poaster is the lead for this project. The project is making good progress.

Future Projects:

Dr. Ewing stated that there are seven topics similar to the type of projects that were on today's agenda that the Commission has prioritized. Staff will prepare briefing papers to outline what projects could look like in adult crisis services, homelessness, school-based mental health, the issue resolution process, mental health/physical health parity, financial reversion policies, veterans' mental health, and the mental health/criminal justice intersection.

Calendar:

There will be no meeting in November.

There will be a teleconference meeting in December.

Commissioner Questions and Discussion:

Commissioner Wooton asked if topic suggestions would be accepted regarding the priority projects for the Commission on consumers and family members, such as peer certification, peer-led organizations, or peer mentors. Dr. Ewing stated that the list of possible projects came from comments from Commissioners over the course of time. He stated that he will add Commissioner Wooton's suggestions to the list.

Commissioner Wooton asked what the vision is with the new projects and the committees. Dr. Ewing stated that the committees have been frustrated in not making as much progress as they would like to. The plan is to draw from all the committees on the topical issues so all perspectives will be incorporated into the project work. More work is necessary to assess how to take the best advantage of the expertise committee members bring to the Commission and how to get the best value.

Commissioner Brown stated that there is a program in Florida that began in 2009, called the Community-Based Residential Competency Restoration Program, which is an alternative to the traditional incarceration model for certain mentally ill criminal offenders. They have Forensic Alternative Centers, which are centers that are run by

mental health authorities rather than correctional authorities and serve as alternatives to jail. They range from secure facilities to community-based residential facilities to semi-independent living facilities. Individuals can matriculate through the different levels and back into the community. He asked staff to research this model to brief the Commission on what is being done there, and an analysis of what are the costs and outcome.

Commissioner Nelson stated that there is a mental health court in San Bernardino County.

GENERAL PUBLIC COMMENT

Ms. Hiramoto stated that it is fine to reorganize and reevaluate committee work, but requested that the process be transparent and that there be committee members who are experts in reducing disparities, which is separate from diversity. Diversity does not equal cultural competence nor does it equal a perspective on reducing disparities.

ADJOURN

There being no further business, the meeting was adjourned at 2:16 p.m.