

MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
November 15, 2012

Double Tree Hilton
835 Airport Blvd
Burlingame, California 94010
866-817-6550; Code 3190377

1. Call to Order

Chair Poaster called the meeting to order at 9:17 a.m. As this was the last meeting he would be chairing, he thanked the Commissioners and expressed his appreciation for the opportunity to work with them and the stakeholders. He also thanked the Executive Director, staff, and retired annuitants for their help, support, and excellence. He stated that he had never met a man more committed to mental health services over a lifetime than Vice Chair Van Horn and that the Commission would be very well served in his hands.

Vice Chair Van Horn stated that Chair Poaster was instrumental in the development of Proposition 63 and has brought the Commission and the mental health system through great progress. Vice Chair Van Horn thanked Chair Poaster for his accomplishments as chair during the past two years.

2. Roll Call

Commissioners in attendance: Larry Poaster, Ph.D., Chair; Richard Van Horn, Vice Chair; Sheriff William Brown; Victor Carrion, M.D.; Senator Lou Correa; David Pating, M.D.; Andrew Poat; Eduardo Vega; and Tina Wooton.

Not in attendance: Assembly Member Mary Hayashi and Ralph Nelson, Jr., M.D.

A quorum was established.

3. Adopt Minutes of the September 27-28, 2012, MHSOAC Meeting
Adopt Minutes of the September 10, 2012, Information Meeting
MHSOAC Calendar, November 2012 – January 2013
MHSOAC Dashboard, November 2012
2013 MHSOAC Meeting Calendar

Commissioner Poat stated that he found the minutes difficult to understand and that they did not fully capture what the Commission accomplished during its discussions. He added that he would clarify in writing some of comments attributed to him.

Chair Poaster asked if there were legal parameters to what type of minutes must be kept. Filomena Yeroshek, MHSOAC Chief Counsel, answered that the Commission had discretion on the format of the meeting minutes.

Incoming Chair Van Horn will discuss this issue with Executive Director Gauger.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Poat, the Commission voted unanimously to adopt the September 27-28, 2012, Meeting Minutes.*

Commissioner Pating stated that Carol Hood's flip chart notes and summary of the discussion at the September 28th meeting helped to capture the discussion; however, that summary was not in the minutes. Executive Director Gauger offered to share Dr. Bradley's summary of that discussion. Commissioner Poat agreed that summaries like these can make minutes more functional by including detail to focus the record on discussion and the decision-making process.

4. Adopt 2013 MHSOAC Work Plan

Executive Director Gauger presented incoming Chair Van Horn and Vice Chair Pating's 2013 Work Plan. It is directly aligned with the Commission's role as set forth in statute, and is modeled after the logic model that the Commission adopted in January 2011.

The Mental Health Services Act (MHSA) is based on the belief that the mental health system can and must be improved. The coming year brings many opportunities to transform the health care system and mental health services for Californians, including integration through the Federal Affordable Care Act, continued reorganization of the Department of Mental Health (DMH) and the Department of Alcohol and Drug programs (ADP), and continued realignment of services at the county level. Through Assembly Bill (AB) 1467, there is a strengthening of stakeholder participation in the planning process and of the expectations around statewide oversight and accountability.

The Commission will pursue eight priorities as it exercises its statutory oversight role in a changing health care environment. The eight priorities are to:

1. Exercise an active role in policy development
2. Ensure evaluation regarding the effectiveness of services being provided and achievement of the outcome measures
3. Exercise financial oversight over MHSA Fund to ensure compliance with statutes and regulations; report to the Administration and the Legislature any concerns or recommendations
4. Ensure that the perspective and participation of community members reflective of California's populations and others suffering from severe mental illness and their family members is a significant factor in all of the Commission's decisions and recommendations
5. Ensure collecting and tracking of data and information
6. Facilitate relevant and effective training and technical assistance (T/TA)
7. Provide oversight of statewide projects and processes

8. Increase efforts to communicate statewide effectiveness of MHSA and overcome stigma

Executive Director Gauger went through the PowerPoint presentation and discussed each of the eight priorities in more detail and listed within each priority, the tasks to be completed by staff throughout the year or referred to the Commission's Committees.

Public Comment

Jim Gilmer California MHSA Multi-Cultural Coalition (CMMC), and the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that the Work Plan is very aggressive and exciting. He added that the arts are broadly defined and encouraged the Commission to consider this in outreach, particularly at college campuses.

Commissioner Questions and Discussion

Commissioner Poat suggested separating the operational roles from the policy roles for clarity. He also suggested changing "any concerns or recommendations" to "assessment" in Priority 3; to include positive feedback, and "effectiveness" to "accountability" in Priority 8, to better communicate the Commission's oversight role. He stated that he will discuss the language of Priority 4 with staff.

Commissioner Wooton suggested adding to Priority 4 a means of communicating back to the stakeholders so they are aware of the outcomes of their participation such as outcomes from the Community Forums. She also recommended including in Priority 8 the names of the Commission's contractors, such as the National Alliance on Mental Illness (NAMI) and the United Advocates for Children and Families (UACF), instead of just saying "stakeholders."

Regarding Priority 8, Commissioner Carrion suggested creating a separate priority for "increasing efforts to overcome stigma" instead of having it as part of Priority 8. As it is currently written it may lead to confusion.

Commissioner Brown recommended addressing the challenges that criminal justice realignment poses to mental health communities in ensuring that those who are formerly incarcerated and being supervised receive adequate mental health services and housing. State funding is insufficient to cover the associated costs. He suggested adding a sub-bullet to Priority 1 addressing these issues in the context of criminal justice realignment. Commissioner Pating added that this could also fall under Priority 3.

Commissioner Correa agreed with Commissioner Brown in that there are inadequate resources to reduce recidivism, especially with the realignment. He recommended focusing resources where they will be most effective and necessary after realignment.

Chair Poaster asked if Vice Chair Van Horn would like staff to incorporate the Commissioners' comments into the Work Plan to which Vice Chair Van Horn responded that it would be best for staff to append the comments to the Work Plan.

He added that the Commission must consider Assembly Bill (AB) 109 and the results of the criminal justice realignment. The prison health system is currently still under federal oversight, but many of the individuals coming out have health, mental health, and substance use disorders; once they become the responsibility of a county mental health or health services program, there is no flexible resource to ensure that these issues are dealt with appropriately. It is unclear what the role of Department of Health Care Services (DHCS) will be in this regard.

Commissioner Brown opined that it is unlikely that the counties will receive adequate funding from the State for this. He recommended that the Commission encourage counties to be creative in their mental health plans and to incorporate services for people in custody or on supervision in the communities. This problem involves the entire community, not just law enforcement or corrections. Each county's community correctional partnership (CCP) includes the sheriff, district attorney, chief probation officer, and other representatives. He encouraged the Commission to send the message that the whole county, including the mental health community, must cooperate to take care of this responsibility.

Commissioner Correa stated that for the first time, California has a surplus, but funding will still be insufficient. The Commission must take a leadership role in defining the funding challenge at the county level. There is a high probability of difficulty in dealing with released individuals' substance use disorders and mental health issues; the backlash from which will lead to initiatives funded by the money currently used to prevent these very problems. He suggested instead that the Commission be proactive and, essentially, fund solutions to minimize this probability.

Vice Chair Van Horn agreed with Commissioner Correa in that problems will occur in the future if solutions are not crafted in advance. He asked Executive Director Gauger to put together a small workgroup of people with interests in this arena to craft a response to the issue as it rises. Commissioner Brown will help the Commission understand which issues are essential.

Commissioner Poat asked whether this will be used to develop charters in the future. Vice Chair Van Horn answered that this will most likely be included in the Services Committee charter.

Chair Poaster asked if Executive Director Gauger had heard any comments from Commissioners that should not be incorporated into the Work Plan. Vice Chair Van Horn and Executive Director Gauger agreed that they did not, but Executive Director Gauger added that she will follow up some of these issues for clarification.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Wooton, the Commission voted unanimously to adopt the MHSOAC 2013 Work Plan.*

Chair Poaster apologized to the members of the public regarding the Commission's meeting packet, which was posted on the website without enough time for the public

to review it. Staff is developing failsafe systems to ensure this does not happen again.

5. Cultural and Linguistic Competence Committee Presentation, “Meeting the Challenge”

Commissioner Carrion, Chair of the Cultural and Linguistic Competence Committee (CLCC) introduced the presentation noting that MHSOAC’s responsibility is to foster cultural competence in all of its services. He stressed the importance of considering cultural awareness in all of its deliberations as it impacts the quality of services, assessment, and interpretation of outcomes. He then turned it over to two members of the CLCC for further introduction and background.

Roger Mitry introduced himself and Monica Nepomuceno, CLCC members. Mr. Mitry stated that the cultural and linguistic appropriateness of mental health services ensures the perspective and participation of individuals and families from racial, ethnic, and cultural communities across the lifespan, and is one of the most important elements in the crafting and delivery of quality services to diverse communities. Culture is more than race, ethnicity, and age; it involves history, generational values, and practices. Culture affects people’s willingness to seek and receive mental health services. Having a greater understanding of culture and its relevance is essential in increasing awareness and having mental health providers fully embrace cultural and linguistic competence. Outreaching, engaging, and providing services in ways that are consistent with the person’s and family’s values and needs are essential in achieving healthy outcomes and mental health equity for all communities.

The CLCC believes in the Commission’s effectiveness and accountability to achieve meaningful ongoing participation from individuals from diverse racial communities and encourages and supports the Commission’s participation in activities and tasks that will produce learning related to cultural and linguistic competence. The goal of reducing disparities and improving outcomes can ensure that individuals have access to culturally-competent and appropriately-responsive services. Because of these reasons, cultural and linguistic competence needs to be integrated into MHSOAC’s work and the standard of reviewing programs, policies, evaluations, and decisions.

The intent of this presentation is to provide information to the Commission about effectiveness in reducing mental health disparities that include welcoming access; quality of care focused on safety, timeliness, and client-centeredness; and healthy outcomes free from stigma and discrimination. Cultural and linguistic competence must be a guiding principle embedded in systems so that service, planning, and delivery are culturally-sensitive to provide appropriate outreach, assessment, prevention, and intervention.

Commissioner Carrion introduced the presenter, Dr. Tamu Nolfo, certified prevention specialist, and a Robert Wood Johnson Foundation Fellow. Dr. Nolfo has worked in social services for twenty years, with a focus on integrating the latest research

development and community needs into strategies for youth and family wellness. She has served as a classroom educator, direct service provider, program developer, coalition coordinator, technical assistance provider, evaluator, and researcher. She completed her doctorate degree in human development at UC Davis with an emphasis in adolescent socioemotional development, and is the manager of the Community Alliance for Culturally and Linguistically Appropriate Services (CLAS) at ONTRACK Program Resources. In 2008, she was named by Sacramento Magazine as one of Sacramento's Most Influential 40 Under 40, and in 2010 was honored as Woman of Excellence from the Sacramento chapter of the National Coalition of 100 Black Women.

A. Presentation: "Meeting the Challenge"

Tamu Nolfo, Ph.D., ONTRACK Program Resources, asked Commissioners to write down their full names, places of birth, languages spoken at home, families' lands of origin, families' religions, and favorite childhood television shows.

She stated that these items are cultural elements, or factors. Dr. Nolfo added that this country often makes White or Caucasian individuals feel like they have less culture than other groups, or even none at all, when in reality, every person has the same amount of culture.

There are many definitions of culture that usually involve values, beliefs, traditions, or other shared characteristics or demographics. Culture comes from family, community, and society, but can also change over time based on individual interests. It helps to define the guidelines for people to get along and establish identity.

Culture impacts everyday interactions, such as the language platform or greetings used. Particularly, culture impacts mental health consumers and providers by playing a major part in the interactions involved in providing and receiving services. It dictates levels of disclosure, physical space and contact, timeliness, level and type of family and community support, stigma and shame, and help seeking norms.

Culture specifically impacts the work of this Commission, influencing decisions such as where to hold a forum or meeting, how to do outreach, how to incorporate feedback from the statewide stakeholder process, and how to ensure that everyone feels respected.

Culture is balanced between individual and group experiences. While each individual's culture is unique, differing even from their family members' experiences, cultural groups can bring individuals together to develop identity, values, and traditions. Health and social services strive to respect that balance by treating patients as individuals while observing the norms and expectations of their cultural groups. It is important to avoid engaging in stereotyping, but it is equally important to use trends, such as collectivity and family-orientation, to the greatest advantage.

Dr. Nolfo referenced the discovery in “Mental Health: Culture, Race, Ethnicity,” a mental health report of the Surgeon General issued in 2011, that racial and ethnic minorities are less likely to have access to or receive mental health services, and often receive poor quality care.

Dr. Nolfo highlighted the difference between race and ethnicity. Ethnicity is a very real concept and includes religions, languages, lands of origin, cultures, traditions, and values; race, however, is a social construct with no biological basis, used to isolate people and justify oppression. Yet, race has very real consequences and must be considered in mental health. She also emphasized the importance of using new evidence-based practices that support the innovations emerging from communities.

The most important reason to provide culturally-competent services is the moral obligation to reduce disparities. In addition, from a business perspective, health and human services practicing cultural competence have a decreased likelihood of liability and malpractice claims, and are able to meet legislative and regulatory accreditation mandates. Cultural competence is the ability of individuals and systems to interact responsively, respectfully, and effectively with people of all cultures. Organizational cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency, or among professionals and consumer that enables that system or agency, or those professionals and consumers, to work effectively in cross-cultural situations.

The five essential elements of a culturally-competent organization are valuing diversity, doing cultural self-assessment, managing the dynamics of difference, adapting to diversity, and institutionalizing cultural knowledge.

The seven indicators of cultural competence in health and behavioral health delivery organizations are organizational values, governance, planning and monitoring or evaluation, communication, staff development, organizational infrastructure, and services and interventions.

The National Standards on CLAS were a way to operationalize the Civil Rights Act of 1964. They came out through the Department of Health and Human Services (DHHS) Office of Minority Health. Even though the Civil Rights Act came out in 1964, it took until 2000 for the government to acknowledge the need to provide guidance on this.

CLAS Standards apply to the work of the Commission in that CLCC’s 2011 Charter requires they develop, produce, and conduct annual cultural and linguistic competence training. CLAS standards are divided into four categories: human resources, language access, program administration, and community linkages.

“Human resources” consists of staff conduct and hiring, including plans regarding recruiting, retaining, and promoting a diverse workforce, as well as ongoing staff education and training.

“Language” access is a mandate within CLAS Standards; the others are guidelines. Lawsuits may occur if language access is not provided to the threshold language groups in a demographic area, usually 3,000 individuals or five percent of the population. Language access includes providing competent language assistance, ensuring clients know that language assistance is available, and providing patient-related materials and signage.

“Program administration” is the most important, as it encompasses strategic planning. The guidance provided for counties is thorough, including such questions as: Is the commitment to cultural competence included in the mission, contract, or accountability? Is there a designated cultural competence coordinator or manager and committee, and dedicated resources? Is there an updated assessment of service needs? Are there strategies and efforts for reducing disparities? Are clients, family members, and communities meaningfully involved? What are the training activities, workforce development, and language capacity? How are services being adapted?

The fourth category, “community linkages”, ensures that the public is aware of both the progress and challenges so they may help to solve some of those challenges.

Dr. Nolfo discussed the National CLAS Standards Enhancement Initiative 2010-2012 which is evaluating the first set of CLAS Standards which were issued over ten years ago. The new proposed 2012 Standards are moving away from decreasing health care disparities and towards advancing health equity; away from a narrow definition of culture as racial, ethnic, and linguistic groups and towards a broader definition that includes geographical, religious and spiritual, and biological and sociological characteristics; towards a definition of health that includes physical, mental, social, and spiritual wellbeing; and towards individuals and groups.

CLAS Standards can provide guidance and support to implement MHSOAC’s strategic plan and logic model. It is essential to have communities involved in the planning process, using resources that already exist within counties. Forecasting and expanding partnerships and needs assessment data are also important. There are exciting new practices on the horizon. The Commission is at the forefront of progress.

Commissioner Questions and Discussion

Commissioner Carrion stated that the Commission needs methods to identify when a decision is or is not culturally competent. The Commission evaluates data with the goal of decreasing disparities and increasing accessibility, and therefore must consider that data may not be valid if the right outcomes are not used for a particular community. Dr. Nolfo agreed and added that there may be a need to take a different approach to data collection. For example, asking what race others consider a person to be, rather than for their own perception, may

have a greater impact in terms of treatment in the health care setting. She encouraged Commissioners to be more creative in data collection and usage.

6. Evaluation Committee Presentation

Renay Bradley, Ph.D., MHSOAC staff, introduced the presentation by stating that the report that will be presented today is an initial step MHSOAC is taking towards continuously monitoring priority performance indicators. Staff hopes to further refine those indicators and to take steps to analyze them so conclusions can be drawn about their current levels. This report is the beginning of the process that Dr. Bradley hopes to continue over the next several years.

A. Presentation of UCLA Final Deliverable: Priority Indicators

Todd Franke, Ph.D., MSW, UCLA Center for Healthier Children, Families, and Communities, stated that he will discuss one part of the priority indicators report, specifically focusing on how the indicators were evaluated and the strengths and weaknesses of those indicators.

The goal of the report was to evaluate the feasibility and use of the priority indicators, to identify how to measure the priority indicators based upon existing data, to recommend additional information, to provide information to support the development of a priority indicator set that is appropriate for regular assessment and monitoring, and to develop a template for reporting.

This report represents a snapshot of the priority indicators and summarizes twelve consumer- and system-level priority indicators across fiscal years (FY) 2008-09 and 2009-10. The indicators evaluated in the report were proposed by the California Mental Health Planning Council (CMHPC) and approved by this Commission. The priority indicator development was an integrative process, including reviewing existing data sources, stakeholder feedback to the reports, and feedback from county representatives regarding the quality and completeness of key data needed to calculate the indicators.

Data was used from as many sources as could be found including consumer and service information, the Full Service Partnerships (FSP), the consumer perception surveys (CPS), the county MHSA plans and annual updates, and other sources used to estimate the need for mental health services and the involuntary status.

The criteria used in the review included:

- Population – Can the indicator provide meaningful and relevant insight into the service population of interest?
- Change – Can the indicator describe changes in consumer status and outcomes?
- Multilevel – Did the indicator provide meaningful and relevant insight into outcomes of consumers or system performance at statewide and county levels?

- Actionable – Did the indicator provide insight that stakeholders can use to identify areas of improvement in consumer outcomes or system performance?

The four consumer indicators were:

1. Average school attendance per year
2. Employed consumers
3. Homelessness and housing rates
4. Arrest rate

The eight system indicators were:

1. Demographic profile of consumers served
2. Demographic profile of new consumers
3. Penetration of mental health services
4. Access to a primary care physician
5. Perceptions of access to services
6. Involuntary status
7. Consumer wellbeing
8. Satisfaction

The service populations were either all consumers or FSP consumers.

Indicator 1: There is no existing data that directly measures school attendance in terms of days attended or absent. What does exist is a question that asks, on a Likert scale, how often the child attended school – never, sometimes, most of the time, or all of the time.

Indicator 2: This indicator has the most complete information and allows multiple views of the data.

Indicator 3: Research and evaluation stakeholders mention that the form primarily used to collect housing information for this indicator might not be used consistently across the counties. There needs to be additional support, training, or definitions about when and how the form should be used.

Indicator 4: There is a fair amount of information available regarding arrest rates and post-arrest activities, such as detention, incarceration, or presence in probation camps, that could be useful, but it has not been vetted through this Commission.

Indicator 5: This indicator must be interpreted with the understanding of inconsistencies year-to-year and between counties. Several stakeholders expressed and supported the idea that the quality of this data needs to be reviewed and that there needs to be effort to ensure all counties are using the same definitions.

Indicator 6: Service levels and demographic characteristics of new mental health consumers served can provide indication of service populations changing makeup and potentially provide insight regarding the extent to which unserved

and underserved populations are entering the community mental health system. This is one of the better system-level indicators at this point.

Indicator 7: As estimates of need of mental health services statewide become more accurate and additional years are analyzed, this indicator may become more informative.

Indicator 8: This indicator is not tracked among all mental health consumers and is only reported among FSPs. Even so, it provides insight into the relative success of FSP programs in connecting consumers with primary care physicians.

Indicator 9: The average ratings indicate positive perceptions of access to services. The data collected in FYs 2008-09 and 2009-10 must be interpreted separately because there was a change made in how the data was collected in those years, in that there was only a random sampling of counties in 2009-10. This data comes from Consumer Perception Survey (CPS).

Indicator 10: The analysis of additional FYs of involuntary status data or disaggregation among various consumer populations will provide further information. Currently, it is known that involuntary status was reported among a relatively small proportion of mental health consumers, and the data was only available for FY 2008-09.

Indicator 11: The average ratings indicate positive perception of wellbeing as a result of services. The data was collected in FYs 2008-09 and 2009-10, but must be interpreted separately because of the change in the sampling method. This, again, comes from CPS. Data should improve by using the same method in upcoming years.

Indicator 12: This also comes from CPS and indicates positive perceptions of satisfaction.

In conclusion, the findings included in the report are preliminary, given that the report details the initial approach to calculating the priority indicators based upon existing data. The existing data sources were not originally designed to support routine assessment of summary indicators of consumer outcomes and system performance at multiple levels, and the brief time period analyzed does not allow for interpretation of trends over time. Most of the indicators will support more accurate assessment and monitoring to the extent that the data becomes more complete and reliable. Few indicators may not be possible or appropriate for ongoing outcome and performance monitoring. Additional indicators and supporting data collection may be necessary to develop a comprehensive outcome and performance monitoring system.

Commissioner Questions and Discussion

Commissioner Vega asked if there is a statistically significant difference between the two FYs, given the varied sample sizes. Dr. Franke answered that there is a test that can be done, but the methods were different for those two years. In one year, the sample was volunteers, and in the other year, it was a random sample.

Vice Chair Van Horn asked Executive Director Gauger if staff was aware of that change. Executive Director Gauger answered she was not aware of it. She asked Chief Counsel Yeroshek if she had any recollection of the data collection process changing between the two fiscal years. Chief Counsel Yeroshek answered that MHSOAC staff had not been involved in any of the data collection methods used during those years and had not been informed of the change in collection methods.

Commissioner Pating stated that he is concerned that consistent education and primary care indicators cannot be found. Education is important because the transition-age youth (TAY) population is one of the most highly-affected areas that show benefits of cost containment. Access to primary care is important because the movement of health reform will be working on that integration. He asked if the two areas with potentially unreliable data that Dr. Franke highlighted will be improved, or if alternate processes could be developed. He suggested contacting the Department of Education and using ADA attendance data and school nurse visits as a proxy for a mental health measure. Dr. Franke stated that some of these things could be done, but it is an ongoing challenge for systems to link their data.

Commissioner Pating questioned whether the indicators were the most possible, the most reasonable, or the most important. Vice Chair Van Horn stated that CMHPC proposed the priority indicators and this Commission agreed, knowing that there were going to be data problems. Dr. Franke added that, in a sense, the results are disappointing, but added that this is a good first step in that staff has learned what needs to be improved or changed for the next step.

Commissioner Carrion stated that efforts towards data consistency across counties should be a priority before the further gathering of data in order to interpret said data correctly. Dr. Franke agreed, but added that the Commission first needs to determine what data is important, and then to provide consistent definitions. The collection must be focused on the most important data. Though all data collected may be important to different entities for different reasons, too broad a collection is a burden on many counties.

Additionally, Commissioner Carrion stated that the timing of data collection is important because, although it is good to have ongoing assessments of indicators, some of them may not show change from one year to the next. He asked if Dr. Franke had any recommendations, since the Commission could be holding and evaluating an ineffective indicator for many years.

Dr. Franke answered that this is a possibility, but this is also an opportunity to see how long an individual received services and to note any changes. Having data over a longer period of time will put the Commission in a better position to track these ongoing changes.

Chair Poaster opined that it seems impossible to determine whether these indicators are the right ones to pursue due to underlying data problems.

Dr. Franke agreed that as to many of the indicators. While the employment category was the best indicator and counties seemed to fill it in more often, there is a significant amount of missing data, and the counties have spoken multiple times about the challenge they face in doing some of this data entry. However, there is some conceptual thought about what should be good indicators.

Commissioner Poat stated that, the first generation of these types of reports initially reveals more of what is not known than what is known. From a positive standpoint, he opined, this preliminary information can be used to design the second generation. It would be a remarkable contribution to public policy to champion growth so that the right questions are being asked and an information system is being developed to answer those questions.

Commissioner Pating asked Commissioner Poat what he strategically sees as a next step towards the second generation. Commissioner Poat shared four questions that the Commission could work toward answering:

- How will this data be used for evaluation now? The Commission must understand what data is the most indicative currently.
- How will the Commission determine the most meaningful data in the future? Some areas may be kept while others may be discarded.
- What will the Commission develop in order to understand this environment?
- What are the systemic changes that are required to support that evolution?

Some of the measures are:

- The design and definition of the measures
- The data systems to support those measures
- The evaluation techniques
- The resulting policy implications

Chair Poaster stated that this report will return to the Evaluation Committee for added detail and recommendations before coming back to the Commission.

Commissioner Vega stated that these seem more like methodical indicators rather than systems indicators. There is a difference between methodical changes, or things that happen as a result of methods, and actual systems differences. He asked how to know if a system is fundamentally different in terms of what it is doing and what it feels like. Vice Chair Van Horn answered that the Evaluation Master Plan will have some of those answers. The studies done so far are discrete looks at pieces of the system.

Commissioner Vega clarified that he was not casting aspersions on any of the work that has been done, but when Commissioners talk about massive-level systems change, they are talking about what they do not have right now, which is a structural look at what is being measured.

Commissioner Poat agreed that one wildly optimistic outcome would be to have each county reporting the status of the position of anyone with a chronic mental health condition within the recovery scale. Commissioner Pating stated that

Dr. Meisel, in her work on the Evaluation Master Plan, has identified three kinds of study buckets. One is performance measures, which were just discussed. These, like the Commission's dashboard, will go up and down. The second bucket is the drilldown questions Commissioner Poat and Commissioner Vega asked. These are evaluation reports on a specific component, question, or idea. The third bucket is the exploratory component that will answer questions such as whether recovery makes a difference in the global health scheme. This study is where the monthly indicators of mental health services come in. The ideas raised are very meaningful, but funding must also be considered.

Commissioner Poat stated that, with results like this, legislators, foundations, and national government can be asked to step in and help create a model in California that can be replicated elsewhere. If the Commission can develop a model, funding will follow.

Dr. Franke stated that an indicator report is being prepared on each county, to be completed at the end of November, to track progress and the data currently in the system.

Commissioner Pating asked if the contract is over with this report. Dr. Franke answered that additional reports will be generated over the next eighteen months, such as gathering data between 2005-06 and 2008-09 to see if there have been improvements.

B. Presentation of UCLA Final Deliverable: Full Service Partnership Costs and Cost Offset

Elizabeth Harris, Ph.D., Evaluation, Management, and Training Associates (EMT), stated that she presented an interim report to the Commission during the summer with partial results from some of the counties. She is now presenting the final report. EMT was charged with calculating a statewide, by-county, annual and per day costs for providing FSP services broken out by age groups, and the potential savings for each of the groups that participated in FSPs. In many instances, these services almost or completely paid for themselves, based on savings to the broader public system.

This study focused on psychiatric care, physical health, and criminal justice for FYs 2008-09 and 2009-10, because the data in the DCR system is the most robust for those FYs. EMT optimized the existing data collected by counties and made use of the large amount of data that has been collected so far in order to tell a more comprehensive story about the impact of FSPs. Additional data was collected by web survey. There were fifty county participants, since the revenue and expenditure data was insufficient to answer the question of cost per age group in every county. The counties that responded represent 50% of the population of California.

The counties estimated the expenditures in terms of the costs of program services and housing. EMT included people who received services during the FYs 2008-09 and 2009-10, and determined an annualized cost per client.

The final numbers are much closer to each other across the age groups than reported in the summer, as the interim report reflected only a partial sample of the counties. There is great stability across the years. In FY 2009-10, the annualized cost dropped, as programs matured and staff became more experienced, consistent across the age groups.

For offset analysis, new FSP enrollees were examined for each of the two FYs for one year prior to enrollment and one year after, in each age group, followed by all offsets, such as arrests, days in State hospital, etc. This was compared to the cost of providing services.

The most exciting area is for TAY – over 100% of their costs are covered by the savings due to reduction in incarceration or in days hospitalized. 82% of adult costs and 97% of older adults are offset due to reductions in in-patient psychiatric hospitalization and incarceration.

Overall, in 2008-09, 75% of the costs were offset by the savings to the system. 2009-10 has a similar pattern, except that the offsets are higher across the board, with 88% of the costs offset by savings to the system. The results are consistent across the FYs across the State. In both FYs, the largest area of savings for adults was reductions in in-patient psychiatric hospitalization. For TAY, it was fewer days of incarceration.

Between the two fiscal years, the combined amount is the most meaningful. A total of 81.8% of costs are offset by savings to the system. This is substantial, given that this only looks at three areas: psychiatric care, physical health services, and incarceration. To have that proportion of costs offset speaks to the power of FSP.

EMT is compiling a report that shows the results by county and, more meaningfully, the reasons for the variation between counties and what drives variation, such as the nature and types of services, the extent and degree in which peers are involved in providing services, how robust the service package is, the rate of insurance, and the Holzer Targets. There are a number of factors that either drive costs up or down.

Commissioner Questions and Discussion

Commissioner Carrion asked whether there really are improvements, or services are not being provided, or people are not seeking as many services in the second FY. Dr. Harris answered that what is received in the program in terms of units of service is missing in the data and is not part of DCR.

Vice Chair Van Horn asked if the 2008-09 clients are different than the 2009-10 clients, and if there are plans to look at the second year costs. Dr. Harris

answered that there are different clients for each FY and there are no plans to look at the second year costs.

Vice Chair Van Horn added that, since it is the first year for these people, it is not a case of improvement, and so, in cost offsets, it must be that part of the drop in costs is that the system had less money to spend. The services cost will be determined by the budget. Budgets shrank because of the reduction in vehicle license fees and sales tax income through Realignment 1, which was in effect in both of these FYs, and a \$100 million shrinkage in State general funds in that period, and must have had some impact on the level of service provided.

Dr. Harris agreed, but added that EMT took the number of people and their service days into account in terms of annualizing the cost. Fewer clients may be served as a result of smaller funding, but this requires a longer-term period of testing.

Commissioner Vega stated that TAY results signal that the Commission should be actively focusing in on this population. He stated that not utilizing the data to drive Commission policies is a problem. The Commission just contracted with California Youth Empowerment Network (CAYEN) as a stakeholder group and recommended asking CAYEN how to maximize the 147% cost offset shown in the report for TAY to begin building on the current data.

Commissioner Correa asked if there are ways to measure savings to early-release prisoners who will not receive any services, to focus services on them, and to make sure they stay out of the system. Dr. Harris stated that it is an issue EMT certainly would be interested in. Commissioner Correa added that the data on the savings of TAY in terms of incarceration would indicate the need to have this conversation sooner rather than later.

Commissioner Brown stated that he is troubled by the savings in booking fees, as they have not been paid by the cities in the old booking fee model since 2006, but that money is offset by the State. EMT may have used an old model to calculate a savings that really is not a cost. Secondly, the cost savings in the report are calculated on a daily jail rate, which is inclusive of all costs associated with the jail, including fixed costs for operation. He recommended focusing on the marginal cost savings from preventative measures, rather than using a division of total cost by number of inmates. Dr. Harris stated that the rates provided by the California Department of Corrections and Rehabilitation (CDCR) for daily incarceration rates were used in this report.

Commissioner Brown stated that that is not an accurate measure of cost savings and may taint the rest of the report in terms of what savings are achieved. This report will be open to criticism regarding the types of cost savings indicated. Additionally, there is a disparity where Los Angeles used a figure of over \$1,000 a day when every other county used a figure substantially lower.

Dr. Harris stated that Los Angeles uses their mental health day rate because incarcerated individuals with mental health issues receive different types of

services. What EMT put forward for the counties was based on input from the evaluation advisory group and data directly from CDCR.

Commissioner Brown stated that other numbers in the report do not accurately reflect counties either. The daily jail rate is different from the actual costs, and it is very different from the fixed cost incurred regardless of the number of inmates. He asked that this be indicated in the report and investigated further in the future.

Dr. Harris stated that, even if only marginal costs were considered, there would still be substantial cost offsets in other areas. Commissioner Brown agreed, but added that the correction would give the report more credence.

Chair Poaster asked that the Evaluation Committee discuss this issue with Commissioner Brown.

7. General Public Comment

Steve Leoni Mental Health Association in California (MHAC), stated that the stakeholder Request for Proposal (RFP) is a major departure from prior contracts. The RFP and the outline were not posted until two days before and went through no Committee. Due to recusal and illness, no client members were present at the Commission during the decision to adopt it. He suggested possibly delaying RFP or revising it to include public comments. He requested the Commission's help to prevent the loss of the historic relationship between the stakeholder group and the State.

Delphine Brody, Public Policy Director for the California Network of Mental Health Clients (CNMHC), stated that California is leading the way with the unprecedented CRDP, which has drawn international attention. She encouraged the Commission to increase adherence to and improve upon CLAS Standards, especially in terms of the administrative areas. She stated that culturally-defined practices are often not included in evidence-based practices, even though they offer the opportunity for adjunct or complementary services as well as culturally-specific holistic services. She encouraged the Commission to consider culturally-defined projects as important to whole populations, and to include them in funding streams.

In terms of the priority indicators report, Ms. Brody noted that disaggregated data collection methods are needed to show equity and disparity for the historically unserved, underserved, and inappropriately-served populations. Indicator 2, in addition to the changes in rates over time for those receiving services, needs to show a baseline twelve months prior to services for employment status. There is a need to measure full-time versus part-time employment, as well as the type of work, wages, and benefits compared to general workforce trends in each respective job market. Indicator 3 also needs a baseline twelve months prior to service, to track changes and to be able to address media.

Karen Moen Collaborative Justice Mental Health Care Project of the Administrative Office of the Court, stated that the majority of mentally ill people are not in the criminal justice system; however, the population that it represents is a unique challenge to the criminal justice system and courts. The Taskforce for Criminal

Justice Collaboration on Mental Health Issues, appointed in 2007, examines this issue; judges form about half of the taskforce, and mental health and criminal justice partners, primarily at the State level, form the other half.

In 2012, the current Chief Justice appointed the Mental Health Issues Implementation Taskforce, which is working to implement the total taskforce recommendations to the extent possible, particularly in the judicial branch. The Collaborative Justice Mental Health Care Project receives MHPA funds, which have supported the work of two taskforces. This project has helped to promote dialogue between the courts, and has been able to significantly expand mental health education for judicial officers and court staff.

Ms. Moen's Collaborative recently surveyed judges appointed between 2010 and 2012; well over half of respondents reported that they desired further mental health education. The Collaborative has conducted research activities and expanded into other areas of more specialized populations, including veterans, homeless populations, and juveniles. Six years ago, the Collaborative began dialogue with mental health and criminal justice partners, which has been fruitful during this period of realignment activities and challenges.

The collaborative, like the Commission, is confronting the challenges that realignment brings and looks forward to addressing these challenges. Ms. Moen stated that the chair would welcome an opportunity to meet with the Commission. She thanked the Commission for its work and the work done to support the effort to better serve all Californians.

Commissioner Pating stated that MHSOAC was on the original taskforce and he was to represent the Commission, before it became a judges-only taskforce with the downsizing. The Commission contributed to the co-occurring disorders component. He asked if AB 109 has come up before the judges. Ms. Moen answered in the affirmative and added that judges have identified some significant issues. In the prison group returning to the community, there is concern about whether State funding will be sufficient to address the challenges. This is being examined further.

Commissioner Pating asked Executive Director Gauger if the Commission can continue this conversation with the Chief Justice Office. Ms. Moen agreed and stated that Director Mayberg served on the original taskforce and Chief Deputy Executive Director Carruthers often attended representing Senator Steinberg's office. The highest priority determined in the taskforce meeting last week was reconnecting with the Sheriff's Association and MHSOAC.

8. Review and Approve FY 2013-2014 MHPA Annual Update Instructions to be Disseminated to Counties

Chair Poaster stated that staff has developed an update format, as State statute requires counties to submit their three-year plans to the Commission thirty days after approval by boards of supervisors. It should be noted that those plans are submitted only to MHSOAC. The law does not specify what MHSOAC is to do with them, although the Commission interprets it as another way of oversight that helps feed

into evaluation efforts. Staff has been working on a standard format to bring consistency throughout the counties.

There are two certifications: the Compliance Certification and the County Fiscal Accountability Certification. Chair Poaster stated that DHCS has concerns about the Fiscal Accountability Certification, and he asked that it be made clear that the motion will be for approval of the format and the first certification. MHSOAC and DHCS will try to come to an agreement to be brought back for the January meeting.

Aaron Carruthers, MHSOAC Chief Deputy Executive Director, stated that Welfare and Institutions Code (WIC) section 5847 instructs counties to prepare an MHSA plan and an annual update. After being adopted by the county board of supervisors, counties must submit these plans to MHSOAC. Because MHSOAC is the only State entity to receive these plans, MHSOAC took the leadership role in drafting the instructions for the plans.

The purpose of the instructions is to ensure that counties know what to do, to collect the essential elements necessary by law, and to provide MHSOAC with the information it needs to track, evaluate, and communicate the statewide impact of MHSA. Also, MHSOAC has the responsibility of approving new and amended Innovation (INN) program plans to ensure it has enough information through these updates to make decisions on those plans. In drafting these instructions, staff adhered to statute and regulations as closely as possible. In staff's view, there is no new policy in these instructions.

The instructions themselves tell counties what should be included in the annual update, which includes a description of the stakeholder process, details about the programs including new and significant changes, the number of people to be served, cost per person, shortages in mental health personnel, specific information about INN programs, and achievement of performance outcomes. Also, these instructions ask counties to include evidence that the board of supervisors updated the plan and the certification of county compliance, as is newly required by statute through AB 1467, and to submit a funding summary to MHSOAC thirty days after adoption by the board of supervisors.

If the Commission approves these instructions, staff will disseminate them and the forms to counties, continue conversations with DHCS regarding the language in the County Fiscal Accountability Certification form, and begin the process of developing the three-year integrated plan instructions through the Committee process.

Commissioner Questions

Commissioner Wooton stated that counties are concerned that, the new law requiring plans to be signed by the board of supervisors and auditor-controller may delay the process. She asked if the board of supervisors can designate another entity, such as the director, to sign off on the plans on an ongoing basis. Chair Poaster stated that to his knowledge this cannot be delegated.

Commissioner Vega stated that there has been a huge degradation of the stakeholder process in both the annual update and general planning. People are

feeling disenfranchised; this is reflected in the fact that there is less interest in and less social and public support behind Proposition 63. Commissioner Wooton agreed that stakeholder involvement has greatly lessened.

Commissioner Vega also added that this is an important opportunity for the Commission to lead with what sounds like a relatively administrative document, but that might be a main form of policy in terms of providing guidance and clarity both to counties and to local stakeholders for what they should expect.

Commissioner Carrion asked if this is the one time the Commission will send recommendations to the counties. Chair Poaster stated that the proposal is an MHSOAC-initiated endeavor to develop some standardization regarding annual updates, and mirrors what is required in state statute. It can be amended, but it is important to get something out to counties now, as it is due in the first half of 2013.

Vice Chair Van Horn stated that there will be opportunities in the 2013 calendar year to work on the development of the three-year integrated plan. That is where a more detailed involvement of the stakeholder community will be specified. The instructions before the Commission today outline and give guidance as to what to include in the annual update.

Commissioner Wooton asked if sign-in sheets or names of persons who attended during the process will be included with the forms that are submitted. Vice Chair Van Horn answered that they will describe who participated, but are not required to submit sign-in sheets.

Commissioner Poat opined that the right direction for public process is to have counties sign that they have met clear criteria. He asked how this procedurally ended up on the agenda today, and if the mental health directors and consumer groups reviewed it. Chief Deputy Executive Director Carruthers stated that the draft was released publicly and organizations were consulted. That is how it was found that CMHDA has no objections to it in its current draft and that DHCS does. Chair Poaster added that DHCS's primary objection is that they want it listed that the signature is under penalty of perjury. Staff did not feel this was required by law or regulations. Commissioner Poat stated that he would be interested in public comment on this issue.

Commissioner Wooton stated that there was a robust stakeholder process when MHSA was first put in place, but that has been watered down over the years. Commissioner Pating stated that this is something the Commission grappled with when doing PEI and INN plan reviews. There was a fine balance between the amount of questions and details asked and the burden on the counties. Stakeholder robustness is not one factor, but a continuum and a developing process.

Commissioner Pating stated that this shows MHSOAC's involvement and allows conversational opportunities with each county to increase understanding of the process. This is invaluable because it creates a relationship and an obligation, working towards the goal of stakeholder involvement.

Commissioner Correa asked why DHCS requires signatures to be under penalty of perjury. Chief Deputy Executive Director Carruthers stated that he believed these standards were imported from Medi-Cal and general accounting practices and standards. CMHDA feels it is not applicable here. Those are federal standards and not needed in MHS.

Commissioner Vega agreed that commitment to a robust stakeholder process is important and suggested including a cover letter from the Commission indicating its commitment to a community-driven initiative. He suggested as a possible cover letter, "This is important to the Commission as you engage with your annual update process. We have seen waning in the stakeholder process over time. We urge and strongly favor a reinvigorated stakeholder process as we move into integrative planning."

Chair Poaster agreed, but suggested it say the Commission "expects" or "anticipates" a robust local planning process per regulations.

Public Comment

Ms. Brody stated that she agreed with Commissioners Wooton and Vega in that the stakeholder processes' robustness and vitality has been lacking in most counties. A concerted, statewide, and state-level effort will be required in order to strengthen that again. This document will be an important step in that process.

Ms. Brody added that greater detail is needed in the annual update description of participating stakeholders and the circulation methods used for public comment. There is not enough detail required to document that those are being done in a conclusive way. There should be evidence that key stakeholders were included in each element of WIC section 5848; measures are needed to show adherence to the general standards in California Code of Regulation (CCR) Title 9 section 3320. Without the documentation to the adherence to these, it will be easy for counties to make ambiguous claims, regardless of penalty of perjury.

Maylen Valois thanked Commissioners Vega and Wooton for their comments on the robustness of the stakeholder process. She stated that more robustness can be demanded but there needs to be clearer guidelines to ensure that this happens. There needs to be information and assurances that there is a time for the public to contribute, ask questions, and voice opinions.

Commissioner Discussion

Commissioner Poat asked if any other guidance exists. He asked if there is any accepted case law or statutory requirements that uphold the public participation standards.

Chief Counsel Yeroshek stated that there are regulations currently, issued by DMH, that specify what the counties have to submit as evidence of participation. As Commissioner Wooton mentioned, sometimes it is a list of attendees at meetings. The issue comes with the transition. Even though the regulations are still in effect, counties are unsure whether they need to follow them because the whole system

has been realigned. Some of these regulations may not be as applicable as they were when they were initially adopted. DHCS will be reviewing the regulations and the MHSOAC will be consulted during the review.

Vice Chair Van Horn asked if, in the Commission's cover letter, it would be helpful to remind the counties that these regulations exist, that they are still in force, and that they must be followed until they are amended. Chief Counsel Yeroshek stated that the instructions do list the regulations.

Commissioner Vega stated that this is an opportunity for leadership. He recommended that the Commission take every opportunity to provide clear ideas and guidance to the communities about this important element of the planning process. Counties are still funded to provide planning; part of their funding goes to stakeholder planning processes.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Correa, the Commission voted unanimously, with one abstention, to adopt the fiscal year 2013-14 Annual Update Instructions without the Fiscal Accountability Certification, and disseminate it to counties no later than 180 days before fiscal year 2013-14 with a cover letter that explains that the regulations still exist and need to be followed.*

9. Training on Conflict of Interest (Government Code section 11146.3) and Brief Overview of the Bagley-Keene Open Meeting Act

Chief Counsel Yeroshek stated that her presentation will be in two parts: conflict of interest and Bagley-Keene. The purpose of the presentation is to comply with the law, which requires that, within six months of taking office and then at least once every two years after that, Commissioners have an orientation course in relevant ethics law.

Conflict of Interest

There are four laws that apply to conflict of interest: the Political Reform Act and three Government Code sections, which apply to contracts, code of ethics, and incompatible activities. The goal is to provide enough information so the Commissioners will be able to recognize a possible problem and seek advice. Each of these four laws must be considered independently. Any given decision could involve more than one law. Conduct that is acceptable under one of these laws may be in violation of another. They are very complex; she recommended that Commissioners contact her with any issues.

Chief Counsel Yeroshek went through a PowerPoint presentation discussing each of the four laws: The Political Reform Act, Government Code Section 1090; Government Code Section 8920; and Government Code Section 19990.

The Political Reform Act is the single most important conflict of interest law in California and seeks to prevent conflict of interest by requiring public officials to disclose specific financial information in Form 700, and disqualifying public officials

who have a disqualifying financial interest. The rationale of the Political Reform Act is that political officials should perform their duties in an impartial manner.

The Political Reform Act states that a public official is prohibited from participating in a government decision in which they have a disqualifying financial conflict of interest. There are two key questions about this prohibition: what does it mean to participate in a government decision, and what is a disqualifying financial interest? Chief Counsel Yeroshek went through the eight-step process established by the Fair Political Practice Commission to determine if there is a disqualifying financial interest.

When a conflict of interest has been determined, the official is to publicly disclose that interest and recuse himself. The official is not required to leave the room, but will not enter into any discussion.

The Political Reform Act includes limitations on receipts of gifts to \$420 per calendar year from a single source. That source has to be a source that is within MHSOAC Conflict of Interest Statement. In January, that \$420 will be adjusted to reflect the consumer price index. Also note that, even though gifts can be received of up to \$420, Form 700 requires disclosure of a gift of \$50 or more. The Political Reform Act also prohibits the acceptance of an honorarium for making a speech or serving on a panel from an entity covered by MHSOAC Conflict of Interest.

The second conflict of interest code, Government Code Section 1090 prohibits an official from making a contract in which they have a financial interest. Financial interest is not defined in the same manner as in the Political Reform Act. It is defined by case law and is defined very broadly. The penalties are very harsh. Recusal or disqualification is not a cure under this Code section, whereas it is a cure under the Fair Political Practice Commission.

The next conflict of interest is the code of ethics under Government Code Section 8920, where officials are prohibited from participating in any decision in which they expect to derive a direct monetary gain or suffer a direct monetary loss by reason of that decision. It is sufficient for an official to recuse himself from this decision.

The last conflict of interest deals with incompatible activities under Government Code Section 19990. This section prohibits an individual from using state resources and prestige for private gain, for using confidential information for private gain, and for accepting a gift intended to influence or reward for making a decision.

Bagley-Keene Open Meeting Act

There are three basic duties under the Bagley-Keene Act: to conduct meetings in open session, to give adequate notice of meetings, and to provide an opportunity for public comment. Chief Counsel Yeroshek went through the PowerPoint presentation and discussed in details the provisions of the Bagley-Keene Act, including the definition of a meeting, prohibition of serial calls or emails, requirements for closed meetings and teleconference, adequate notice of meetings, and opportunity for public comment.

10. Mental Health Funding and Policy Committee

A. Adopt Revised Financial Report Template

Commissioner Poat stated that the Funding and Policy Committee at least twice a year presents an assessment of the direction of mental health public system funding - once in January after the Governor introduces the state budget and then around after the May Revise.

There were some concerns with the previous format of these fiscal reports, in that if there was unfamiliarity with State budget processes and an inability to read fairly complex documents, the reports may be lost on the general public. The Funding and Policy Committee revised the format and is presenting it for Commission adoption. Commissioner Poat credited MHSOAC staff member Kevin Hoffman with putting this project together.

Commissioner Poat went through the PowerPoint presentation and discussed each of the graphs.

The “Community Mental Health Funding Amounts – Role of Major Funding Sources” graph shows the total funding that is in the public mental health system. The color designations indicate the different types of funding that go into the public mental health system. The Committee chose this format because it shows the total level of funding from one year to the next, and it shows what the components of that funding are and identifies potential shifts in the funding source from year to year, such as the amount of General Fund state revenues that go into the public mental health system, and the role that Proposition 63 funds now play in the state mental health system.

The “MHSA Revenues Received” graph illustrates the total amount of MHSA revenues each year. This is important because it most directly relates to the funding that comes through MHSA and, therefore, is technically under the jurisdiction of this Commission. This has been one of the more volatile funding sources in the public mental health system. This graph serves to alert the Commission to any required shifts in policy in order to accommodate fluctuations in revenue.

The “MHSA Funding – Approved/Distributed/State Administration” graph shows the amount of money that goes to State administration. The goal has been to keep the amount of funds used for administration to the lowest level possible, because any savings can then be put over into the services category. Mr. Hoffman added that this chart also represents all components.

The “State Administrative Fund by Department” is a new chart and will show who receives the administrative funds. Mr. Hoffman added that the Department of Finance breaks down the administrative funds by departments, which will enable this chart to be populated. Commissioner Poat stated that the charts will not only show the total amount in State government for administration, but this new chart will show where it is going by department.

The next chart tracks the housing program. This chart will show how much has been dedicated, how much has been committed to a project, how many of those projects have turned into reality, and how much might be sitting around waiting to be turned into reality.

The “Key Fiscal Indicators” chart is a placeholder and is one of the innovations of this report. It will include more narrative, and bulleted conclusions that will describe fiscal policy decisions that are being proposed and/or adopted by the governor and the legislature. This narrative chart will help explain the specifics of the budget proposals.

The “County Distribution of Funds” chart measures the distribution of funds among the counties. It takes three pages to list all of California’s fifty-eight counties in different FYs to track, over time, what has happened in particular counties.

Commissioner Poat stated that Appendix 1 through Appendix 3B provide the details and background information for charts 1 through 4.

Mr. Hoffman added that there will be an additional appendix corresponding to the Housing chart.

Commissioner Poat stated that the revised template is the product of Committee meetings in which stakeholders were engaged, putting out the historic report, sending out a proposed update, and receiving comment back on that update in writing, emails, and phone calls, and one subsequent Committee meeting.

The revised template is an improvement in that it gives more of the information needed to assure taxpayers that their money is being spent effectively, provides that information in a more user-friendly format, and starts giving a fuller picture of the entire public mental health system.

No public comment was made on this agenda item.

Motion: *Upon motion by Commissioner Wooton, the Commission voted unanimously to adopt the Revised Financial Report Template.*

11. Commissioner Comments

Commissioner Carrion stated that he wanted to ensure that the Commission keeps track of the issue of data consistency across the counties. Chair Poaster stated that this will be part of the follow-up discussion to the data heard today.

Commissioner Poat suggested that the Commission be involved in studying standards for cultural competency. Vice Chair Van Horn stated that it may be added to CLCC Work Plan to look at the amended CLAS Standards as they come out.

Vice Chair Van Horn stated that there was a request from Betty Dahlquist, at the U.S. Psychiatric Rehabilitation Association (USPRA), for the Commission to direct counties to put some of their MHSA dollars into helping get people out of institutions for mental disease (IMDs). The nursing homes that are not Medi-Cal-covered are warehousing a lot of people at this time. He stated that he told Ms. Dahlquist the

Commission does not tell the counties how to spend their money, but it is an issue that needs to be looked at. It has been a big issue in Los Angeles, where they have spent a lot of time helping people get out of IMDs and into FSPs. This is an interesting issue to think about in the move toward a recovery- and resiliency-oriented system.

Commissioner Vega stated that, as this Commission evolves, it is important to recognize there is an opportunity to shift from an administrative role to a leadership role. Over the last several years, due to Chair Poaster's efforts, this Commission has already moved in that direction. Now there is an opportunity to take that to another level. Under the Commission's new leadership, there will be opportunity to lead in various ways by putting out good information and having good communication. He encouraged Commissioners to take that challenge to the next level.

Commissioner Pating stated that it is unclear post-AB 100 what policy tools the Commission has to make the changes it wants, whether in commenting on AB 109 or IMDs. Evaluation has been the Commission's main tool, but it is more retrospective; the Commission should be thinking about what its policy tools are, and how much it wants to activate them, whether by going to the Legislature, public announcement, or press conferences; they carry varying amounts of risks and benefits depending on how they are implemented.

Commissioner Poat stated that MHSOAC has the capacity to introduce legislation to gain more regulatory power. Commissioner Pating stated that there are always policy implications of being a nonpartisan, stand-alone Commission, and hoped that has some value as well in being an independent voice.

Executive Director Gauger reminded Commissioners that MHSOAC still has the authority for PEI and INN guidelines.

12. General Public Comment

Ms. Brody stated that she was pleased that the Commission meeting locations are starting to move around the State again, but encouraged the Commission to consider more accessible areas for mental health clients and unserved and underserved communities.

Ms. Valois stated that she had a complaint regarding mental health board membership selection and did not know who to ask for help. The last time there was an opening on the Santa Clara mental health board, the applicant was hired immediately. The second time there was an opening, the process took two months. She asked a member of the internal committee to review applications when the applications would be reviewed, and was told the chairman would put together the committee. However, the meeting had already taken place. The secretary would not tell Ms. Valois why the committee member was unaware the meeting had occurred, who was in the committee, or if the chairman of the board attended the meeting. For some reason, they did not want that committee member to be present at the meeting. Ms. Valois discovered that nominees are "rubberstamped," because the supervisors do not have time to do background checks. The process is something

like a bill: supervisors have a list of things to approve, and there is basically no recourse. Ms. Valois thanked the Commission for its help.

13. Adjourn

Chair Poaster adjourned the meeting at 4:00 p.m.