



Mental Health Services Oversight and Accountability Commission
Meeting Minutes
January 30, 2009

Hyatt Vineyard Creek Hotel
170 Railroad Street
Santa Rosa, CA 95401

1. **Call to Order**

Chair Poat called the meeting to order at 9:08 a.m.

2. **Roll Call**

Commissioners in attendance: Andrew Poat, Chair; Larry Poaster, Vice Chair. Linford Gayle, Beth Gould, Tom Greene, Patrick Henning, Howard Kahn, Bill Kolender, David Pating, Darlene Prettyman, Eduardo Vega, Richard Van Horn.

Not in attendance: Richard Bray, Mary Hayashi, Larry Trujillo.

Twelve members were present and a quorum was established.

3. **Adoption of November 2008 Meeting Minutes**

Motion: Upon motion by Commissioner Kahn, seconded by Commissioner Henning, the Commission approved the November 2008 Minutes.

4. **Welcome from Sonoma County Mental Health**

Mr. Mike Kennedy, Director, Sonoma County Mental Health, welcomed the Commissioners. He noted that Sonoma County's population is about 470,000; the city of Santa Rosa has about 150,000, and most of the city services are located in Santa Rosa. However, through the MHSA they have been able to cover services in Cloverdale, Guerneville, Petaluma and Sonoma. They have services in each of those cities on a weekly basis.

The mental health division served about 9,000 clients last year and about 1,300 were children. There are 168 staff.

Director Kennedy highlighted some of the MHSA programs available in the county and their level of staffing.

The Community Intervention Program is an outreach and engagement program that targets a number of hard-to-reach and underserved populations. It serves the homeless and improves access to the ethnic minorities in the county. It also provides services for people with co-occurring disorders. County staff is a part of that team and positions are also funded at sites in the community. The county staff comes in and works at the service sites on a part-time basis, alongside with the people assigned to those sites. Other sites include:

- The Santa Rosa Free Clinic. A psychiatrist is onsite a day and a half per week and the clinic provides mental health services as well as health services. They also collaborate with the local family practice residency. The Free Clinic also offers Vet Connect, where homeless veterans can come in and connect to a number of services onsite. County staff also provides backup to the local library and does mental health interventions. The downtown law enforcement group will call them and they will come and do assessments in the field.
- County staff goes to a drop-in center in Santa Rosa on a weekly basis and works with on-site staff.

Mr. Kennedy showed several slides, including slides of:

- The Mary Isaak Center.
- The Samuel L. Jones Hall, an 80-bed year around facility.
- The Redwood Gospel Mission.
- The Living Room for Women.
- The Sloan Women's Emergency Shelter.

County staff also works with several federally qualified health clinics, including the Southwest Community Health Center, Indian Health Project, Inc., Alliance Medical in Healdsburg and Vida Nueva, a new housing site with 24 units in Rohnert Park, which also uses MHSA monies.

There are also a number of consumer-run programs, including the Interlink Self Help Center and Russian River Empowerment. The Wellness and Advocacy Center offers fully paid staff managed through Goodwill Industries.

Sonoma County is about 22 percent Latino and they are in the process of increasing their access to the Latino population. Without MHSA they would not be able to do what they are doing now and the Act really keeps services intact as much as they can be.

Commissioner Pating thanked Director Kennedy for his PEI application, which is currently before the Commission. They view it very favorably and it is really a wonderful application.

From the perspective of the application it is apparent that Sonoma County is doing a terrific job of integrating their services.

Commissioner Gayle asked if there is a family affairs office. Director Kennedy responded that they have a number of advisory committees that work with them and they also have a family advocate position.

5. Introduction of New Commissioner and Honoring of Former Commissioners

Chair Poat welcomed new Commissioner Richard Van Horn, who will be serving as the appointee from the Superintendent of Education. Commissioner Van Horn is President and CEO of the Mental Health Association of Los Angeles and was the principal consultant for MHSOAC at a critical early juncture.

Commissioner Van Horn expressed his delight at being a part of the Commission. He has attended all but the first OAC meeting. He is excited about the opportunity to really build the partnerships with community clinics and schools that are essential to the transformation of the mental health system.

Chair Poat then honored former Commission Chair Linford Gayle and former Commissioners Wesley Chesbro and Mark Ridley-Thomas. Former Commissioner Ridley-Thomas was unable to attend the meeting.

Executive Director Whitt thanked former Chair Gayle for all his “behind the scenes” help during the Commission’s transitions during the past year; and for being an incredible role model and leader for her, the Commission and Commission staff.

Commissioners Pating, Prettyman and Vega and former client Kevin Murphy also expressed their appreciation for Commissioner Gayle. Chair Poat then presented him with a plaque and he thanked all the people who supported him.

Chair Poat thanked former Commissioner Chesbro for his help and years of service.

Commissioners Henning, Prettyman and Pating and Executive Director Whitt expressed appreciation for his service and thanked him for always being there for people with disabilities. Commissioner Gayle thanked him for being such a strong advocate for the consumer movement in California. **Chair Poat** presented a plaque to former Commissioner Chesbro, who thanked people for their support and reminded them that protecting and defending what needs to be protected and defended is important work.

6. MHSOAC Priorities for 2009

Chair Poat, in collaboration with the OAC staff and committee chairs, presented some priorities for 2009. He began by outlining four major priorities for 2009:

1. To fund and execute all five MHSOAC Programs, both county administered and statewide.

2. To adopt and implement the Integrated Plan.
3. To see continuous improvement in the oversight, accountability and transparency framework.
4. To identify the path towards transformation of the mental health system.

The five **Priority 1** MHSA Programs to be funded include:

Community Services and Supports (CSS), which accounts for 55% of MHSA funding. There are three types of funding: Full Service Partnerships (FSP); General System Development to improve programs, services and supports; and Outreach and Engagement to the unserved and the underserved.

The first three year cycle has been completed and 58 programs have been approved (57 counties and the City of Berkeley).

The counties will be submitting annual updates for their July 1 funding. The OAC's plan review and comment is based on DMH-adopted guidelines. The integrated plan/project review process will be adopted sometime in 2009.

Counties apply for the funds on a project by project basis. Fourteen counties have submitted 20 projects; seven have been awarded thus far and 13 are in review.

In terms of regulations, the integrated project review process is in design and the target date is summer 2009; OAC comments on regulations will probably be adopted in June 2009.

Prevention and Early Intervention (PEI) represents about 20 percent of overall MHSA funding; some is county-administered, some statewide. The OAC is the lead agency for the program and establishes the initial round of funding. Almost \$29 million has been distributed so far. There are 10 client plans in review and it is anticipated that 42 counties will apply for funding in 2009.

PEI state-administered programs include Suicide Prevention (\$10 million per year over 4 years), the Student Mental Health Initiative (\$15 million per year over 4 years), Stigma and Discrimination Reduction (\$15 million per year over 4 years) and the Reducing Disparities Project (\$15 million per year over 4 years). State-administered training and technical assistance is also assigned to counties (\$6 million per year over 4 years).

Innovation (INN) represents 5% from CSS and 5% from PEI; the total amount for 08/09 and 09/10 is \$71 million. The target date for adoption is Summer 2009.

Capital Facilities/Technological Needs (CFTN) has funding of \$453,400,000 and counties have ten years to spend the funds. Seven county plans have been submitted and target date for adoption is also summer 2009.

Workforce Education and Training (WET) has two components: county programs have 10 years to spend \$210 million; and statewide programs have \$240 million for training, technical assistance and financial incentives. Sixteen county plans totaling \$26 million were approved as of October 2008.

Priority 2, the implementation of the Integrated Plan, includes guidelines development and adoption and the use of a review tool to assess results.

Priority 3, Continuous Improvement, has three components: 2009-2010 state budget issues; financial management; and program management. It takes a long time for money to move into the system -- are there ways to get that money to circulate faster? There is also a 5 year program evaluation that will be designed and conducted in 2009 and concluded sometime in 2010.

Priority 4, Transformation, has the goal of catalyzing a consensus pathway to mental health transformation. It includes input on community collaboration and cultural competence; needs to be client-and family-driven; includes wellness, recovery and resilience; integrates service experiences for clients and their families; and has Co-Occurring Disorders (COD) competency.

These ambitious priorities will involve a lot of work. Much of the work will be done in the various OAC Committees, which will be convened by the Commission and include a chair and co-chair from the Commission, members from the stakeholder community, and approximately 15 members total who will provide recommendations to the OAC for adoption/approval.

Committee chair/co-chairs are:

- ***Mental Health Funding:*** Tom Greene, Chair; Larry Poaster, Vice Chair
- ***Evaluation:*** Larry Poaster, Chair; Richard Van Horn, Vice Chair
- ***Client & Family Leadership:*** Eduardo Vega/Darlene Prettyman, Co-Chairs
- ***Cultural & Linguistic Competence:*** Richard Van Horn, Chair; Eduardo Vega, Vice Chair
- ***MHSA Services:*** David Pating/Beth Gould, Co-Chairs
- ***Executive:*** Andrew Poat, Chair, Larry Poaster, Vice Chair (includes one representative from each committee)

Chair Poat acknowledged that some of the stated timeframes for adoption may not work, and asked that Committee Chairs notify him when they need to be adjusted. He also invited comments and revisions to the presentation.

Commissioner Van Horn stated that the integrated plan issue will probably need changing; **Chair Poat** responded that this is absolutely correct. The Commission will be briefed on that subject at the February meeting.

Commissioner Henning asked how the California Mental Health Planning Council fits into this structure. Also, the formalization of the Executive Committee is problematic. Limiting the membership to one representative from each committee creates potential difficulties. **Chair Poat** responded that somehow there must be effective communication between meetings and they are searching for that method. **Commissioner Henning** agreed, but cautioned that formalizing an executive committee structure, although designed to streamline communications, may not serve that purpose. **Vice Chair Poaster** expressed his appreciation for Commissioner Henning's comments and wondered how to balance the work so that minimal duplication occurs.

Commissioner Kahn suggested that probably what needs to happen is to get these thoughts down in writing and then Commissioners can react to that. What we have currently is a lot of supposition. If the Executive Committee is to be formalized then clearly it must be run in compliance with the Brown Act, which has several implications to it. However, if it's less formal it may go in a different direction.

Commissioner Kahn further stated that, given that money is going to be driving much of what they do, a discussion of what the Commission's fiduciary responsibility is to the Act and how that plays out in the context of the state budget situation will determine a lot of what they do in the future. **Chair Poat** agreed and looks forward to the presentations later today that will lay that out and provide a framework on the types of information they will want to see monthly and quarterly and the types of key issues they want to engage in.

Vice Chair Poaster suggested that the best way to resolve the situation right now is to give it some more thought. Also, how many crossover issues do various committees have?

Commissioner Vega stated that he favored the Executive Committee idea because it lends to decreasing the worry about lack of transparency. Some of the large scale questions about how the Commission uses its meetings and preserves the value of keeping important voices in the thinking process is something that the Executive Committee can help solve, although he is unclear about some of the specific issues and problems that may be created.

Commissioner Henning clarified that he fully supports the Chair and Vice Chair and the decisions they need to make. However, in the history of creating executive committees oftentimes voices get left out when some decisions need to be made.

Commissioner Pating stated that the question for him is what kind of authority the Chair and Vice Chair need in order to move forward in a flexible manner. Right now there is fast movement coming out of the Capitol.

Chair Poat expressed his appreciation for the comments. He further stated that his goal as Chair, his job, is to be an ambassador on behalf of the group. The group needs to pass judgment whenever it can and he needs to be able to speak with the majority of the Commission. Hopefully we can have an approved position from this Commission in time to be relevant to each of the decisions that have to happen in the year ahead. His goal is that, whoever is speaking for the Commission, they will have 100 percent confidence that they are articulating a Commission-

approved position. If we can stick to these timeframes, at least from what we can anticipate today, we will have an approved Commission position on every key issue we need to have in order to get all the programs operational, all the plans approved, etc. Chair Poat and Vice Chair Poaster will discuss further where they see the Executive Committee going and put that down on paper.

Commissioner Pating wanted to ensure that by the end of the day Chair Poat has whatever authority he needs to respond to the budget crisis as it unfolds.

Commissioner Prettyman stated that the Client Action Committee seems to be duplicating efforts with the Cultural Linguistic Committee. She doesn't know why both of them are working on suicide prevention, student mental health, and input from community programming. **Chair Poat** responded that perhaps by the February meeting this can be worked out.

Executive Director Whitt commented that very soon there will be an additional resource in the form of a house counsel who will take on as her first task formalizing the Commission's rules of procedure. In addition, the Commission has an interagency agreement with the Attorney General's Office for legal services by Shannon Chambers, who is primarily available to provide counsel around broader issues related to the Act

Commissioner Kahn suggested that as the year goes on the Commission may want to evaluate the number of meetings and reduce that down, which may improve the public input and Commissioner participation.

Chair Poat asked the OAC staff to update the Charters for each committee to include the timeframes and responsibilities noted in the presentation. He and Vice Chair Poaster will work on putting forth a clearer vision of Executive Committee responsibilities.

7. Mental Health Funding Committee Report

Mr. Mark Heilman, DMH Community Services Division, provided an overview of MHSA funding. Some highlights:

- The MHSA imposed an additional tax for each taxable year beginning January 1, 2005. The new tax was imposed at the rate of 1% of taxable income in excess of one million dollars, which represents between 20,000 and 30,000 returns and is highly sensitive to fluctuations in the economy.
- There are three primary sources of deposits to the MHSA fund: cash transfers, which account for 1.76% of all monthly personal income tax payments (not just millionaires); annual adjustments (made in July); and interest income, which is posted quarterly.
- The MHSA fund balance is "lumpy" throughout the year since monthly cash transfer amounts vary.

- The annual adjustment represents about 1/3 of all MHSA annual funds. It is calculated on tax returns from two years prior and is deposited 18 months after the end of the tax year it is earned in. Thus, it can vary significantly, depending on the economy.
- These variations in annual funds affect the distribution of overall funds. Counties need to rely on a steady stream of funding to ensure program continuity, so funding for local MHSA Programs reflects revenue on a cash basis, not on the projections of revenue. The cash basis allows counties to rely on the level of funding, known in advance, and allows for program continuity over time.
- Counties are notified of available cash through planning estimates, which are based on all cash deposits projected to be on hand on July 1st of the planning year. For example, revenues collected in FY 08/09 will fund planning estimates in FY 09/10. Generally, counties received 75% of cash requested when the plans are approved; the remaining 25% of approved cash is released upon receipt of the required fiscal reports.

Commissioner Greene then commented on some of the emerging policy issues. The first issue is money in the bank. MHSA has generated more than \$4.1 billion in additional revenues through the end of FY 07/08. However, just under \$2 billion has been distributed through the end of FY 07/08. There will always be a balance in the MHSA Fund because cash accumulates so that counties can receive their funds whenever they request them. In addition, revenue accrues to the Fund throughout the year.

However, estimated revenues are declining. Projected revenues for FY 07/08 are \$1.5 billion; in 08/09 that drops to \$1.3 billion. In 09-10 it remains roughly \$1.3 billion, then drops below \$1 billion in FY 11/12. Thus, over a five year span the system goes from a roughly \$1.5 billion system to roughly a \$1 billion system, a loss of a third of the money.

How does the Commission want to deal with this reality of declining revenues?

The second major policy issue is supplantation. The MHSA, section 15, states that “funding . . . shall be utilized to expand mental health services . . . [and] . . . shall not be used to supplant existing state or county funds to provide mental health services.” However, the current FY 09/10 Governor’s Budget proposes to take \$226.7 million of these funds.

Another issue is Prudent Reserve. Guidelines say that Prudent Reserve should be set at a level of 50% of the most recent annually approved CSS funding level, and this 50% level should be fully funded by July 1, 2010.

The next issue is to clarify the policies in place in order to avoid a two-tiered system; i.e. does someone new to the system get only MHSA funding?

Commissioner Vega asked if the Prudent Reserve is exclusively county funded. **Commissioner Greene** responded that it is a county by county reserve and is not state funded. Counties differ greatly in terms of how much prudent reserve they currently have on hand.

Commissioner Greene further clarified that the numbers presented do not take into account any supplantation decreases. Thus, if the Governor's Budget goes through as proposed, the funds would decrease by \$226.7 million.

Mr. Don Kingdon, California Mental Health Director's Association (CMHDA) Deputy Director, then provided a series of slides detailing MHSA funding and how it might change given the changing climate. The overall question to wrestle with is *Do you set policy first and then finance or does finance drive policy?* One of the problems in California is that the state's dependency on federal funding sometimes drives policies that the state may not agree with later on.

He described the "big four" in funding streams that are tracked over time. They include SGF -- the State General Fund (which is now shrinking as an overall proportion of the funding pie, and that may continue); FFP -- Federal Financial Participation (the largest funder by far but there are often significant delays from the time the claim is submitted until the funding arrives); R -- Realignment (transfer of responsibilities from the state to the county through sales taxes and vehicle licensing fees); and the MHSA -- the Mental Health Services Act.

The problem today is cash flow; counties may or may not receive funding in a timely manner. The ultimate financial risk to maintaining services while waiting for cash is the county's not the state, which leads to many of today's problems, as it becomes more difficult for county's to acquire loans to carry them through until funding arrives.

Patricia Ryan, Executive Director, CMHDA, gave a short presentation that detailed some of the policy implications that counties deal with because of these funding streams. As old revenue streams are crumbling and new monies come in from MHSA, how do we make the system funding work effectively?

The ultimate objective is a continuum of care in the community that provides a transformational system for everyone. The MHSA was written to build upon the existing system of care, not to create a separate program. It is attempting to prevent the negative outcomes associated with Serious Mental Illness (SMI) and Severely Emotionally Disturbed (SED) and is also equipped to offer individuals the right amount of services at the right time to improve quality of life.

One of the lessons learned from implementation of the MHSA is that we must simplify and streamline requirements and use performance measures and program monitoring to ensure accountability.

The MHSA provides a roadmap to achieving a continuum of care by adding to and building upon existing statutory requirements in the California Welfare and Institutions Code (WIC) related to community mental health services. There is a need to support timely and efficient implementation of the MHSA by removing any unnecessary barriers to transferring funds from the MHS Fund into local communities for services and interventions. Flexibility must be built

into the system and clarified so that counties fully understand how to obtain funds from the varying sources without violating regulations.

In summary, the two-tiered system (MHSA, non-MHSA) needs to be dismantled; the money needs to get to the local communities; and both needs can begin to be achieved by clarifying and considering more flexibility with Full Service Partnerships (FSP).

Mr. Rusty Selix, Executive Director, California Council of Community Mental Health Agencies (CCCMHA), stated that the real problem is in understanding the range of things that can still be called an FSP. The term Full Service Partnership is not in the Act. The term “Full” means “whatever you need” and has been taken to mean that a huge thing is needed. Some people need less than others. “Services” means the array of services. “Partnership” has two parts -- first is the partnership between the client and family being served and the provider or county being responsible for those services that determine what is needed; second is the original model of an integrated service agency that eventually people realized was not always realistic and what it means now -- a partnership of different entities working together to provide all that’s needed, with a single person as a manager trying to put it all together.

Where we want to get to, to eliminate the two-tiered system, is a point where “that’s all there is.” It’s what everybody gets. It starts from who’s in the system and what do they need and everybody gets whatever they need. We need to clarify how things are put together, to make things more like an FSP. When something is called an FSP it automatically triggers the evaluation criteria, the outcome measures that we have, and the accountability we need.

There is one type of borrowing that the Act does not prohibit. That is borrowing for the purposes of funding the actual services in the Act. If counties have more money they can manage the cash flow for services much better than they currently do.

Dr. Stephen Mayberg, DMH Director, expressed his appreciation for the presentation on mental health funding issues and stated that it underscored how important it is to take all the issues into account as decisions are made.

He noted that the regulations do allow for more flexibility than is generally understood. For a person to be eligible for an FSP they need to meet one of two criteria -- first, either they are SMI or SED or have a condition that would contribute to a substantial impairment of function; and second, they need to meet one of the categories of at risk for homelessness, involvement in the criminal justice system, or at risk of institutionalization.

The regulations do say that the priority should be the people who have been unserved, and the Act does talk about increasing the number of people who have access to the mental health system.

FSPs are defined as everything; but really the emphasis is on “service,” not on “full.” People need different things at different times in their trajectory to independence. It is absolutely

important that the providers understand that there is much more flexibility in the regulations than most people have interpreted.

MHSA programs can use the same people and facilities as previously, but something different is being done. MHSA means people doing new programs that are consistent with the values and goals of the MHSA.

It is essential for us to integrate our systems. How do we get the whole system to fit together? DMH's goal is to stabilize the systems, have them work together, and maximize the flexibility.

Regarding Prudent Reserve, we do not want to be in a situation where we can't ensure a steady source of money and services. If we plan this right, knowing that we are using a cash basis, it should allow us adequate time to deal with the crisis coming in FY 11/12. Thirty percent is a big reduction.

There needs to be an open process so everybody knows where we're going. The updating of the regulatory process needs to be done thoughtfully and deliberately.

Chair Poat thanked Director Mayberg for his words and commented that the key word he has heard today is flexibility. There is a tremendous amount of discretion that has been used in the first five years of the Act and now is the time to determine what has worked and what needs to be changed.

Commissioner Gayle commented on the tremendous amount of information just presented and it is unfair to the Commissioners if they feel that they are unable to ask questions because they've run out of time.

Chair Poat responded that today's motions will be to set up to propose three recommendations which will be developed in committee. The principle opportunity to comment on the information will be in the committees over the next couple of months.

Commissioner Gould stated that pulling together all of this financial information is extremely helpful and it should be placed into a binder for future Commissioners to peruse.

Director Mayberg stated that DMH is developing some Frequently Asked Questions to assist counties as they work their way through the budget situation and the issues surrounding the flexibility of MHSA and other plans.

The Commission then discussed how best to proceed with the proposed motions outlined in the day's agenda. **Chair Poat** asked if there was a Commissioner ready to adopt the proposed motion that the Mental Health Funding Committee work with stakeholders to develop policy recommendations concerning potential flexibility in the use of MHSA funds, and steps needed to authorize such flexibility, for consideration by the Commission at its March 2009 meeting. Commissioner Vega made the motion, seconded by Commissioner Pating. Public Comment followed.

Public Comment

- Ms. Janet King, who works at the Native American Health Center, stated that it is not necessarily a two-tiered problem, it is a multi-tiered problem, with many people not only left on the doorstep but many miles away from it. In Alameda County, Native Americans and several other ethnic groups received zero dollars from the CSS plan.
- Mr. Michael Wilkins stated that financial guidelines should include funding designated for inclusion, leadership and the hiring of family members and cultural brokers in all phases and all levels of the MHSA.
- Ms. Kate Howe, Mendocino County, discussed the three recovery centers in her county. Events have occurred to upset the plan of the MHSA in her area and people have not been allowed to be a part of the decision making process of that plan. The major thing is that the Willits recovery center has not been given the opportunity to have the financial support necessary to keep them open, even though the number of people in Willits is similar to the number in Ukiah. The MHSA plans are open for written comments only and it will probably be decided that there will not be a Willits center, and we're talking about 75 people per week. This is wrong and it needs to be dealt with.
- Ms. Delphine Brody, California Network of Mental Health Clients, expressed concern about the first proposal for flexible funding. Chair Poat clarified that the motion for today is to bring back recommendations regarding flexibility. Ms. Brody noted that their concern is that supplantation has already taken hold and the Act is already jeopardized. Also, they strongly support the letter to the Governor that opposes the move to supplant the \$227 million of MHS monies.

Regarding the second proposal on the financial framework, they feel that the framework should always include funding for inclusion of clients, family and cultural brokers in all phases of the MHSA process.

On the third proposal, they urge that the wording specify that we want transparency in the counties with regards to all decisions. They are not seeing the transparency that is needed in the stakeholder -- locally or on the state level -- which is essential for clients, not only to maintain trust but to participate in the process. They want the report to include reporting on supplantation itself. More discussion is needed on what supplantation is.

- Ms. Patty Gainer, a consumer empowerment specialist, Sacramento County, opposed allowing counties any more flexibility in their MHSA financial matters. Sacramento County's legal counsel says that there are too many legal problems to provide clients and family members with reimbursements for expenses they incur for their essential, significant work in MHSA planning, such as outreach and engaging more clients, family members and others served in unserved populations, and in representing these groups. This is despite the fact that the OAC and others at DMH have assured them that

reimbursements are legal, and DMH will provide training and technical assistance for counties to do this. Other counties, notably LA County, do provide reimbursements.

By not providing reimbursements Sacramento County is not the exception, it is the rule. I have heard awful reports from other counties about lack of outreach and inclusion of clients and poor transparency. My county hired several mental health staff at the MHSA office but none of them have been designated clients or family members. Clients have testified numerous times before this Commission about these problems and requested that the Commission approve a formal grievance process for clients and their counties, but I've never seen any planning for it. These are basic needs of clients and family members that remain unfulfilled.

There is a lack of outreach, inclusion, leadership, compensation or at least reimbursements or an appropriate grievance process, yet the Act itself requires clients and family members to be involved in leading at every step and every level of MHSA. Until the Commission shows improvement in meeting these very basic needs, I see no reason to extend to the counties more financial flexibility.

- Ms Dorothy Friberg, Sonoma County, stated that she has worked with this process from the get-go. She sees raiders on their money; just like Somali pirates. You took our voice away. When I hear "flexible" I hear raid, I see people trying to come in and raid the money that we sweat blood for. If they want more money, let them pass their own law. Let them go through what we went through in Sacramento to get the law passed and then they can have their own bundle of money. But don't let them raid our money for FSPs which cost, like, \$90 a minute. Also, I don't think transparency is available in your own budget planning. Did you have a client on that planning group? Clients are mandated to be involved in every step of this process.
- Mr. Arnulfo Medina, California Youth Empowerment At Work, stated that they support the motion to have more discussion on this because with transition issues one of the biggest problems is the issue of not just the level but the types of services. The transitions that young adults are making are very unique. The other issue we would like more discussion on is the notion of a two-tiered system. We also agree with multiple cultural brokers who believe that this has been a problem in the past. It's a multi-tiered system and we need to eliminate it. We all agree in the end result but we need more communication about what process we used to get there.
- Ms. Molly Brassil, California Primary Care Association, representing California's community clinics and health centers, echoed Janet King and Arnulfo Medina. She expressed her hope that caution will be exercised as we move forward. If we talk about flexibility and integration, then we are looking outside of the traditional mental health system. If we're going to transform the system we need to look outside of it. Many individuals in the state are never going to seek services in the traditional mental health setting.

- Ms. Dede Ranihan, NAMI California, thanked the funding committee for their hard work. She echoed Commissioner Greene's suggestion that part of the February agenda be devoted to this issue, as there are many differing opinions and confusion and the idea is very complex. They look forward to the FAQ, which they can distribute.
- Ms. Stacie Hiramoto, REMHDCO, welcomed Commissioner Van Horn to the Commission. She expressed support for the motion and thanked Commissioners Greene and Poaster for their work on the funding committee. REMHDCO, along with the Center for Reducing Health Disparities and the DMH Cultural Brokers, will be asking the Commission for time at the February meeting. They are excited to work together and would like to put on a panel of information to go over complex issues. For example, the term "two-tier system" -- they have a preference for the term "multi-tier system."
- Ms. Katherine Elliott, Center for Reducing Health Disparities, echoed Ms. Hiramoto's comments and said they are pleased to have formed a collaboration with REMHDCO and the DMH Cultural Brokers. They will be able to work collaboratively to bring the voice of some of their most vulnerable communities to the table. She requested time at the funding and policy committee meeting to address their concerns.
- Ms. Carolyn Chadwick, Tessie Cleveland Community Services, Los Angeles, REMHDCO, and the Cultural Brokers Group, thanked DMH and Rachel Guerrero for understanding the need to seek ethnic communities' input and for convening the Cultural Brokers Group, who support the motion on the floor. They also respectively request 30 minutes at the funding and policy committee meeting.

The three organizations will coordinate a presentation on their views on the flexibility of use of MHSA funds, concerns with language used by some advocate groups when discussing the makeup of the underserved and the unserved communities, and why they have reservations with characterizing the mental health system as a two-tiered system. They would also like to share their recommendations regarding FSPs with the Commission.

Improving access to mental health services for historically underserved and unserved communities and the reduction of disparities in mental health across socioeconomic and racial/ethnic groups are key priorities of the MHSA. The Act was created with the expectation of a comprehensive planning process within the public mental health system that is inclusive of California's most vulnerable population, such as the ethnically diverse, the poor, the unserved and the geographically isolated. The hope is that bringing new partners to the table will improve the access to the mental health system, to communities who have never had admittance to it before.

On a personal note, she has attended a couple of meetings previously and it's a little dismaying that, when time is reduced, it's always a reduction in the time for public comments.

- Ms. Cheryl Maxson expressed her strong reservations regarding flexibility. It seems to her that you are going back on the work that was done before. The broken stuff needs to die; it needs to be swept out and thrown in the garbage. Now it seems like what you're saying is let's bolster that up and try to save it. If the horse is dead, bury it. For example, we are required under the DMH traditional system to keep X number of beds, whether you use them or not, and that's very expensive.
- Mr. Ricco Zappitelli, a caregiver, stated that a family member of his is a client of Manzanita Services. He appreciates the enormous job that needs to be done. He is not an attorney and what he is hearing is very legalese. He is concerned about needing to talk to the common man. Doesn't California law mandate that clients are included in this decision making process? And if so, why has he seen no clients? He would like to see a panel where clients are involved in the decision making process.
- Mr. Joseph Reynolds, a client with the Manzanita Center, stated that he has been helped by the Center. To see people have such a need for these programs and to see others who want to slice and dice them -- we could stand it when people would tell us that the schedule was changing but somebody has yet to come and hear what we have to say. There has to be something that can be done other than "this is what has to happen." If we cooperate and collaborate with each other then we both can decide what to do. The clients have to be in the decision making with the administrators.
- Ms. Stephanie Welch, CMHDA, stated that it is obvious that there is a tremendous amount of complexity, both fiscal and programmatic, that was presented today. Things have been happening very quickly and the most important thing for people to hear from the presentation is that these were critical issues that needed more time and discussion and thought.

In terms of timeframes, most counties are very eager to submit their 09/10 plans by March 1st in order to get paid on July 1, 2009. The issue is not so much about program as it is about fiscal. She doesn't want people to leave today with the impression that there is clear instruction with program other than what is compliant with current regulation. So, there is an enormous amount of work that needs to be done. But there is an opportunity to do that work collaboratively and together. In terms of timeframes, most counties will be putting together their plans, potentially, before your March meeting.

- Dr. Rocco Cheng, Los Angeles County Pacific Clinics and member of Cultural Brokers Group and Reducing Stigma and Discrimination, also supported the motion for more discussion regarding the flexibility issue. He worries about one-sided opinion and not giving things enough thought. This is not the time to be divisive. He supports collaboration of different entities to come together and create more mutual understanding and enhance cultural competence. The two-tiered system is easy to understand but is also very misleading.

- Mr. Sherman Blackwell, a longtime Sonoma County resident and committee chair, Multicultural Services Committee, NAMI California stated that his Masters Thesis was on looking at the effectiveness of the Psychiatric Disabilities Act and how it affects the developmentally disabled in the state of California. If there were a mental health law it would preclude those complications, it would give the individual entitlements. We wouldn't be competing over realignment funds, we'd be in an entitlement area, and this would not be a problem. Oftentimes people think of Prop 63 as a cure-all but we need to look at other ways to bolster the mental health system.
- Ms. Linda Picton, Sonoma County addressed her comments to Commissioner Van Horn and asked if it were possible to integrate the larger question of economic and social justice into the process. The services for the most needy always depends on the continued discretionary spending of the consumer class, and we're kind of experiencing that right now. It's time for the right to life to include the right to livelihood.

Following Public Comment, **Chair Poat** asked for a vote on the proposed motions listed in the Agenda. Commissioners discussed the wording of each motion, made changes they deemed appropriate, and voted as follows:

Motion: *(Previously motioned by Commissioner Vega, seconded by Commissioner Pating.) The Mental Health Funding Committee will work with stakeholders, including DMH, to develop policy recommendations concerning potential flexibility in the use of MHSA funds, and the steps needed to authorize such flexibility, for consideration by the Commission at its February and March meetings. The motion carried unanimously by voice vote.*

Motion: *Upon motion by Vice Chair Poaster, seconded by Commissioner Van Horn, the Mental Health Funding Committee will develop a financial framework for regular financial reports, including recommendations on the frequency and timing of such reports, to keep the Commission informed of important financial information for Commission adoption at the February 2009 meeting, to include:*

A: A forecast of funding of the so-called Big Four programs (State General Fund, Federal Financial Participation, Realignment, and Mental Health Services Act);

B. Fund balances and reserves;

C. Critical policy decisions raised by the financial information provided to the Commission, as well as anything else that the Committee deems appropriate for its report.

The motion carried unanimously by voice vote, except for Commissioner Henning, who abstained.

Motion: *Upon motion by Commissioner Van Horn, seconded by Commissioner Prettyman, the Mental Health Funding Committee will report on the effects of filling*

county Prudent Reserves during a time when tax revenues may be declining, and make policy recommendations on this issue at the April 2009 Meeting. The motion carried unanimously by voice vote.

Commissioners discussed the continuing state budget problems and their potential affect on MHSA funding, as well as the proposed supplantation of \$226.7 million in the current version of the Governor's Budget. A letter expressing these concerns was drafted prior to the meeting and will be sent to the Governor on OAC letterhead. It will be signed by individual Commissioners in addition to the Chair.

***Motion:** Upon motion by Chair Poat, seconded by Commissioner Henning, the Commission approved sending a Letter to the Governor and the Legislature regarding redirection of MHSA Funds in contravention of the MHSA. The motion carried unanimously by voice vote.*

8. Adopt PEI State-Administered Project on Reducing Disparities

Ms. Rachel Guerrero, Chief, DMH Office of Multicultural Services, gave a presentation on the revised draft of the \$1.5 million Reducing Disparities Project, which has two focuses:

1. To establish an MHSA Multicultural Collaborative;
2. To develop a comprehensive strategic plan to help design the \$60 million statewide project.

Expected outcomes of the \$60 million statewide project include:

- The largest mental health investment specifically for racial, ethnic and cultural communities;
- New service delivery approaches defined by multicultural communities for multicultural communities;
- New PEI approaches, defined by communities, training models, partners, evaluation methods, improved outcomes, etc., to support healthier communities;
- New strategies developed across five targeted communities to improve outcomes and reduce disparities;
- Stronger infrastructure for inclusion of multicultural communities; and
- Replicable service approaches to reduce disparities.

Public Comment

- Ms. Brassil stated that the California Primary Care Association strongly supports the revised draft of the Project and commended DMH for doing a great job at working with stakeholders during this process.
- Mr. Medina, on behalf of the California Youth Empowerment Network, commended DMH for allowing the opportunity to do a project like this.
- Ms. Welch, CMHDA, commented that counties have not traditionally contracted, and it would probably be appropriate for them to be involved in this process, particularly in reviewing and developing the strategic plans, so they can ensure that they are ready to implement them and ready to contract with other individuals to provide the services the strategic plan identifies. Also, the multicultural collaborative -- is that ongoing? Will counties be included in that process?
- Mr. Pedro Toledo, Director of Community Government Relations, Redwood Community Health Coalition, stated that their community clinics serve about one out of five people in their region (Sonoma County). Any funding that can come to their local county would be greatly appreciated.
- Ms. Chadwick stated that the Cultural Brokers Group supports the project. They applaud DMH for listening to their stakeholders and abandoning the same old "one RFP" approach and going with an innovative way of doing this.
- Dr. Cheng, Pacific Clinics, echoed the previous speakers and commended DMH for listening to community input. He sees this as an example of a true transformation. When he hears that it is developed by and for the community, he knows that his community is very touched. There is definitely an opportunity to build capacity in the community but no resource to use. This is an opportunity to put like-minded people together to share resources. He is hopeful that more capacity will be built.
- Ms. King, Native American Health Center and member of REMHDC and Cultural Brokers Group, stated that all three of the groups she represents are very excited that these RFPs are being voted on today. She expressed appreciation for Rachel's attempt to give them some time to process, as this is a non-linear kind of activity for ethnic communities to come together.
- Ms. Hiramoto, REMHDCO, stated that they are delighted to see this RFP, which really models what the transformation can be. DMH took the steps to really get stakeholder input and she has heard nothing but praise about the way DMH handled it.
- Ms. Harriet Markell, CCCMHA, remarked on how impressed she has been over the last 7-8 months at the way that DMH was willing to step back and take another look at how they were going about the project. The new plan has the opportunity to create a very inclusive, in-depth, thorough, well-thought-out plan for reducing disparities, and it is critical that California do the right thing. She also hopes that DMH knows that providing

money for the different communities to be able to participate in this process is going to be critical and the administrative issues are also critical.

Members then discussed the appropriate wording for the motion.

***Motion:** Upon motion by Commissioner Van Horn, seconded by Commissioner Gould, the Commission adopted the report relative to how DMH is proceeding with the Strategic Plan for the statewide PEI project on reducing disparities, with encouragement to accelerate the final delivery date sooner than the January 2011 projection. The motion carried unanimously by voice vote.*

9. PEI Consent Agenda

Ms. Ann Collentine, OAC staff, presented staff's recommendation for approval of two county PEI Plan Approval Summaries:

San Diego County's plan includes 24 projects spanning all age ranges. The County made extensive efforts to ensure community involvement and careful consideration was given to provide services for the underserved populations in locations not associated with traditional mental health services.

Humboldt County's plan has three projects -- suicide prevention, stigma and discrimination reduction, and transition-age youth (TAY).

***Motion:** Upon motion by Commissioner Van Horn, seconded by Commissioner Pating, the Commission formally approved the PEI plans for San Diego and Humboldt Counties.*

10. Closed Session

[The Commission considered materials related to personnel matters. The closed session occurred only because the discussion could have implications on staff, which is a permissible exception under state law for preliminary consideration by the Commission. At such time as these decisions will potentially become official or adopted they will go through a public process.]

11. Open Public Comment

- Mr. Raul Matamoros expressed concern that in Ukiah and Willits the counselor's hours used to be 8-4, but now it's been cut to 10-3. That's not enough hours for the counselors to take care of us and help us. The rest of the hours are spent out on the streets. You know, take your choice. Do you want peace or do you want violence? It's simple, it's a very simple thing. These people are homeless, they're probably mentally ill. I've spent 14 years on the street and I know what it means to be out on the streets.
- Ms. Brody, California Network of Mental Health Clients, commented on client membership on several of the committees. They would like to see clients get involved

with the Mental Health Funding Committee that made today's proposals. Also, she is unsure about client membership on the Evaluation Committee. Indicators need to be developed to show how peer-run services have been so effective in keeping people out of hospitals and saving money in counties -- an essential process for the Evaluation Committee.

- Ms. Maxson, Modoc County, thought that it would be highly effective if the client and family leadership had a strong showing and involvement in the financial question and answer period and in helping to craft the language in a way that the average person would actually understand what the question meant. Maybe it could be done in different sections, on color coded pads or something, just to make sure that it was in all the threshold languages. And she wants to be a part of that; just let her know.
- Ms. Rosemary Milbrath, Director of NAMI, Sonoma County, expressed her appreciation for the comments Commissioner Gayle made early in the day and agreed that families and clients in leadership roles and in partnership with county mental health departments have been and will continue to be key to transforming the mental health systems. NAMI is grassroots and they have observed that multicultural families are underserved and unserved and they wish to encourage funding to address disparities that come down to the local level. This work must be community born and community informed. They are not seeking funding for themselves but they want that funding available for the appropriate agencies that can give that help on the local level. She expressed appreciation and thanks to the Commission for all the work they do to support families and clients.
- Mr. Toledo, Redwood Community Health Coalition, stated that a majority of his clients are underserved people of color. In two of his communities they have had good experiences with the PEI process. In two other communities people were not engaged sufficiently; they were not meaningfully involved as required by MHSA regulations. They have been working with their local counties and submitted comments and done their due diligence and research and forwarded that on to their appropriate boards.

They are working with their elected officials in the hopes of helping to increase access to the people they serve. Accountability and transparency are key and they need to make sure that the people who need the services most in their community get access to them. So he really wants to thank Ms. Whitt and the Commissioners for directing their staff to work with them and help in resolving this issue.

- Ms. Ellen Goldstein, Fred Finch Youth Center, San Mateo County, proposed that trauma-informed care as outlined in the guidelines and implementations for the MHSOAC statewide project be included in the technical and training portion of the initiatives. It's overseen by the MHSA Services Committee. The trauma-informed care and trauma-informed services are nowhere seen in that huge packet of information.

She saluted what has been done by the Commission thus far. She congratulated Commissioner Pating for his efforts on the COD report, which has really informed her

county and encouraged and inspired them to create a trauma-informed services work group.

Within three months they have put together a 300-participant conference and training called Moving Toward A Trauma-Informed System of Care, to be held on May 12, 2009. They are also piloting integrated screening tools and assessments for trauma-informed care, a learning collaborative to disseminate trauma-informed practices and interventions to agencies, and co-occurring and trauma tracking tools. So, they are on the forefront of big things and want to share that wealth and ensure that they are included and supported by the Commission.

- Ms. Sandra Davis, a client, goes to the Manzanita Center in Ukiah, which has helped her get stronger. She suffers from bipolar PTSD. They have been extremely helpful. One of her concerns is the funding being cut and them losing their services. A lot of people come through there, 20-30 per day, for help and support services, and it is helpful to them. It helps her get through the day. To see it get cut is really hard. She signed up to be a peer support person and now she finds out it's not going to happen. She wants to know if anyone can help them get that fixed so they don't have people missing out on the services.

12. Adjournment

Chair Poat thanked Commissioner Greene and Commission staff for their help. He stated that many things were learned today and important decisions were made. They also learned how difficult it's going to be to stick to a one day Commission Meeting schedule. He apologized to everyone for the need for abbreviated comments. He adjourned the meeting at 5:24 p.m.