



Meeting Minutes
June 25, 2009

California Institute for Mental Health
Sequoia Room
2125 19th Street, 2nd Floor
Sacramento, California

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. Lou Correa, Linford Gayle, Beth Gould, Tom Greene, Patrick Henning, William Kolender, David Pating, Darlene Prettyman, Larry Trujillo, Richard Van Horn, and Eduardo Vega.

Not in attendance: Richard Bray, Howard Kahn, and Mary Hayashi.

Thirteen members were present and a quorum was established.

3. **Adoption of May 2009 Meeting Minutes**

Executive Director Whitt commented that a stakeholder who was quoted in the May Minutes had phoned the staff and wanted the language modified; this will be done. Also, **Commissioner Vega** requested a change to Section D, pages 6 and 7, regarding election of the Chair -- it should state that election of the Chair would not be limited to non-consecutive terms.

Motion: *Upon motion by Commissioner Kolender, seconded by Commissioner Greene, the Commission unanimously adopted the May 2009 Minutes as amended above.*

4. **Budget Update: Prudent Reserve Issues and Recommendations**

Chair Poat prefaced by noting that at the April meeting, the Commission had requested information on the prudent reserve. **Commissioner Greene**, Funding and Policy Committee Chair, and **Vice-Chair Poaster** had thus put together this PowerPoint perspective. **Commissioner Greene** gave the presentation.

The state is facing a troubling funding scenario at present. Pertinent questions are:

- What should be “prudent” use of the reserve?
- What kind of policy questions might be raised?
- What actions need to be taken to ensure that the money is going to individuals who need the services?

Commissioner Greene began by underscoring that, in light of California’s budget chaos, the situation is extremely fluid. He presented the latest numbers with an Estimated MHSA Revenues chart. It showed that FY 09/10’s total revenues are \$1,429.8 million; in FY 10/11 they drop to \$866 million; in FY 11/12 they drop again to \$674 million; and in FY 12/13 they rise to \$958 million. Management of the reserve becomes acutely important with the coming drops in FY 10/11 and 11/12.

The bona fide prudent reserve applies to Community Services and Supports (CSS) dollars only. Its law and regulations follow these statutes:

- Section 5847 (a)(7), which states that a prudent reserve must be established “during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and California Consumer Price Index.”
- Section 5847 (f), which gives some statutory guidance: you can tap the Reserve in order to provide services to the same number of individuals that the county had been serving the previous fiscal year. In this way the Reserve protects services.
- Department of Mental Health (DMH) Information Notice 07-25, which provides guidance as to the meaning of “prudent”: it should be 50% of the annual CSS.
- DMH Information Notice 07-25, which states that the Reserve should be taken into account during the planning process. The Commission becomes involved in the planning process when it engages in the Planning Estimates. Most important, the county can access these funds only with DMH approval. This results in enormous policy implications for MHSOAC.
- Prevention and Early Intervention (PEI) and AB 5xxx Section 5847 (b)(7), which states that for the PEI portion of MHSOAC’s work, there should also be a prudent reserve. The same language applies as that of CSS, in terms of adjustments by changes in state population. There is no clarity in terms of how much this really means, and most importantly, when to use it.

Commissioner Gayle commented that programs are now failing for lack of funding, and the next fiscal year is going to be even worse. He asked who is supposed to push for release of the reserve; is it the MHSOAC? Who is supposed to ask DMH to come up with a policy to protect or save some of these mental health programs?

Commissioner Greene responded that it is the counties who have asked. The process is in progress, and hopefully DMH will issue a regulatory statement about when counties can begin tapping reserve funds. DMH is in the process of creating a calculus showing when prudent reserve funds can be tapped. Once a structure is in place allowing MHSOAC to disperse those funds, when do we want to do that? The counties' Planning Estimates will set the amounts they can spend. MHSOAC may want to constrain some funding at the outset in order to have more later.

Chair Poat emphasized that the purpose of this presentation is for the Commission to develop a perspective on what needs to happen, by whom, and when.

Commissioner Greene explained the two kinds of quasi-reserves:

- **Unrequested Funds** are not specified in the Planning Estimates. They remain available to counties upon the approval of a county plan.
- **Unspent Funds** have been distributed to counties and have not been expended.

Commissioner Greene remarked that some counties have reserves in significant amounts while others have a tiny fraction. At this point there's nothing MHSOAC can do for counties that have very little.

Vice Chair Poaster asked if counties have until July 2010 to establish their prudent reserves.

Commissioner Greene responded that DMH had given them an Information Notice that they should have 50% in place not later than July 1, 2010. However, they don't have to do this if it will affect their ability to serve the consumers in their counties. There's a general reluctance among the counties to put something in their bank accounts when there's no obvious way of pulling it out. That's why a regulation of some kind or a statement from the DMH is so critical.

Commissioner Prettyman inquired whether all reserve funds have to be used for MHSA programs; **Commissioner Greene** replied that they should. Unlike the IOUs that the state issues, MHSA dollars, which the MHSOAC oversees, are real dollars. They can be used to match federal programs, etc. The counties are getting hammered because they're not getting cash from the usual sources (i.e., the State of California), so the definition of MHSA programs may become much broader than it has been historically.

Commissioner Greene presented two recommendations.

1. MHSOAC supports the timely development of written policies by DMH regarding:
 - A. Access to prudent reserves.
 - B. Establishing prudent reserves which cover PEI consistent with AB 5xxx. (This understanding is essential for counties to do long-term planning of this volatile funding source.)

2. MHSOAC representatives participating in the development of recommendations regarding future Planning Estimates will obtain input from the MHSOAC Funding and Policy Committee, and will prioritize the use of all reserves to stabilize MHSA-funded programs over time as a guiding principle.

Ms. Carol Hood, MHSOAC Consultant, remarked on the Commission's authority to write guidelines with respect to PEI. This concerned the discussion about who should be influencing or writing policy about prudent reserves. Ms. Hood explained that, typically, DMH has done guidelines, while MHSOAC has had the approval of expenditures for PEI and Innovation. AB 5xx indicated that the Commission is now expected to issue guidelines, so it needs a mechanism. It also needs clarity on who does the work and who has the authority for issuing the guidelines regarding PEI and the funding.

Ms. Pat Ryan, Executive Director of the California Mental Health Directors Association (CMHDA), portrayed the issues counties are struggling with. The intention of the prudent reserve was to ensure that counties could sustain services during years of economic downturn. The requirement for counties to put money into the reserve is in the guidelines, and they must accomplish this by June 2010. Some have done this; many have not. Unexpended funds in individual counties means that the counties are waiting to get clear guidelines from the State on how and when they can access that money.

Counties are well aware of the funding environment for community mental health. For example, how can they accommodate the drastic reductions in the Medi-Cal Managed Care allocation, as well as the failure of the State to pay for AB 3632 services. Counties must take all this into consideration while they are projecting, five years out, funding for needed MHSA services. It's complicated financing. Some communities don't want their counties to put money into the prudent reserve until they have assurances that money is going to be available to them. These communities, as well as counties, feel frustrated and lack trust in the State.

DMH has explained to the counties that the prudent reserves trigger will be pulled in FY 10/11, when the first funding downturn is going to occur. Counties need guidance on when they are expected to begin rebuilding the prudent reserve once the trigger is pulled. They also need guidance on how PEI dollars will add to CSS dollars to build a prudent reserve. Currently, counties are already keeping money aside to fill the prudent reserve; they have questions about timing, guidelines, and process.

Ms. Stephanie Welch, CMHDA, added information about Planning Estimates. If counties are building a prudent reserve and put money aside, it will get them through the very low Planning Estimates that will be FY 10/11, 11/12, and 12/13. For those years, there won't be a lot of money to "hold back" from the Planning Estimate. The strategy MHSOAC needs to focus on is: how do they get through those three difficult years, and how do they have an accessible prudent reserve to fill in the gaps? Not knowing how to access it, and what documentation and forms they need to provide, is of great concern to them.

CMHDA supports MHSOAC's two recommendations. MHSOAC is already a partner in the process of looking at the numbers and determining the Planning Estimates. CMHDA looks forward to MHSOAC's involvement in FY 10/11.

Chair Poat asked how to assure stakeholders that the State won't raid the counties' prudent reserves. **Ms. Welch** replied that an Information Notice would be helpful. **Commissioner Van Horn** asked for an estimated date on the Information Notice; **Commissioner Greene** presumed that the Commission would see something fairly soon.

Chair Poat wondered what the estimated reserves are currently. **Commissioner Greene** gave a number of 50% or more for some counties, and for others far less. The total is roughly \$100 million. Adding up the revenue decline over the next three years, it's about \$2 billion.

Public Comment

- **Ms. Sandra Marley**, a client and a family support member, asked how many groups are involved in the guidelines process. Does it include county directors? She also believed that MHSA was funded to stand on its own; however, AB 5xxx provides a way for the Legislature to become involved. The people did not vote on this; AB 5xx is an infringement on what the voters wanted.

Commissioner Comments

First, the Commissioners discussed the following motion:

“MHSOAC supports the timely development of written policies by DMH regarding A) access to prudent reserves and B) establishing prudent reserves which cover PEI consistent with AB 5xxx.”

Vice Chair Poaster expressed his desire for more urgency in the recommendation, with language that would require DMH to consult with MHSOAC regarding establishment of the prudent reserve as it relates to PEI.

Chair Poat requested that DMH keep MHSOAC staff apprised of the progress of regulation development. Discussion ensued regarding the urgency to the counties. **Executive Director Whitt** explained their urgent need to submit amendments to the FY 09/10 Annual Updates so they can put money into their prudent reserves now.

Following discussion, the first recommendation was reworded as follows.

The Commission supports:

- A) The development of written policies by DMH regarding access to prudent reserves for non PEI programs to be communicated to the counties by July 31, 2009 and direct the Commission Chair, Vice-Chair and the Funding Committee chair to work with the DMH director to achieve this goal.

B) The MHSOAC Executive Director will develop, in consultation with DMH, CMHDA, and other interested stakeholders, written guidelines/policies on PEI prudent reserves for consideration at the July meeting.

***Motion:** Upon motion by Commissioner Van Horn, seconded by Commissioner Gayle, the Commission unanimously approved the motion as amended above.*

The Commission voted on the second recommendation.

The MHSOAC requests that the Mental Health Funding Committee propose recommendations on the future year planning estimates by August 2009.

***Motion:** Upon motion by Vice Chair Poaster, seconded by Commissioner Van Horn, the Commission unanimously approved the motion.*

Commissioner Greene continued the presentation with an update on the state budget. The situation continues to be very fluid. Currently there are two significant facts: one, there are insufficient votes to increase taxes, even on tobacco products; and two, the State is facing a significant cash crisis.

It is generally understood that money required to fund state government, when the Legislature cannot pass a budget on time, comes from borrowing. In the past Wall Street has provided the borrowed dollars while the Legislature debates. However, this year Wall Street will not participate. The Controller must begin issuing IOUs, so there will be enormous pressure on the state government to get a budget passed.

Commissioner Greene stated the budget adjustments to the following mental health programs:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -- one of the most successful programs in the history of California. The State General Fund (SGF) fluctuations:
 - Reduce by \$53.4 million SGF to reflect elimination of state support for county programs.
 - Increase by \$226.7 million SGF to reflect the rejection of Proposition 1E.
 - Increase by \$19 million SGF to reflect the Emily Q court order.
 - Decrease by \$4.9 million to reflect revised caseload.
 - Decrease by \$122.1 million SGF to reflect enhanced federal funds under the federal ARRA.

For the prior year cost settlement for EPSDT (the money the State owes the counties), the deferred payment of \$15.79 million for the 2006-07 deficiency will be deferred to 2010 (the State has already spent the money).

- The Caregiver Resource Center Program will be reduced by \$3 million SGF.
- AB 3632 (basically special education children), will be a deferred payment of \$52 million for past claims. (Again, this is money the State has already spent.)
- The Healthy Families Program for the Children's Health Insurance Program Act (CHRIPA) reauthorization will increase \$1.4 million in federal funding to reflect the enactment of the federal CHRIPA. This results in a SGF savings of \$704,000.
- For the Healthy Families Program, the Administration has proposed complete elimination of funding. Action has been deferred.
- Medi-Cal Managed Care, possibly the state's most important medical program, faces significant funding impacts:
 - Eliminate state support for mental health services other than "federally required inpatient hospitalization and medication services," for a reduction of \$64 million SGF.
 - An increase of \$4.1 million SGF to patient caseload and technical adjustments.
 - Adjustment in the allocation "to recognize increased federal funds as provided in ARRA," for a reduction of \$53.5 million SGF, and a corresponding increase in federal funds.

Commissioner Henning stated that the Budget Change Proposal (BCP) concerning Medi-Cal Managed Care has been approved and has support from both sides of the aisle. It grants \$500,000 to the Department of Veterans Affairs to provide mental health services to the California National Guard. The money comes out of the 5% Administrative Fund.

This BCP shows that the Legislature found a quick way to get money out into the field to help these veterans. It also shows that MHSOAC needs to be more involved in the way its budget, as well as the larger Prop 63 budget, fluctuates.

Ms. Ryan explained two serious problems that the counties are dealing with at the local level.

1. The State is cutting in half the money for managing the Medi-Cal and Mental Health Managed Care Program. The current year's funding was \$225 million. In 1995 the State turned over management of this complicated program to the counties, recognizing that they would do a better job. The funding allocation has been chipped away several times in the past few years. From the counties' perspective, costs are going up for providing services while the counties receive a flat or reduced amount. Currently the State is saying it is only obligated to pay counties for what they are federally required to provide, which is in-patient hospitalization and medication services.

Counties are also trying to figure out how to communicate with beneficiaries, who are very confused about how and if their benefits have changed. Regarding the

elimination of the psychology benefit -- even though the State is saying that outpatient benefits are optional, it is telling beneficiaries that they can get their psychology benefits from the counties.

2. The State is clearly choosing not to comply with the State Constitution with regard to paying counties under the AB 3632 program. The Legislative Analysts Office pointed this out to the Conference Committee: the State currently owes counties \$160 million, going back to 06/07, for the state mandate. It is required to either suspend the mandate on counties or fully pay the mandate. Counties are now in a position of having to take legal action to get payment for services they are mandated to provide.

Realignment funding, because of its tie to sales tax and vehicle license fees, is down about 15%. The resulting decrease in revenues to counties is about \$150-\$160 million.

Ms. Ryan concluded by stating that the counties are having major issues at the local level. They are trying to figure out how MHSA plays into all this, and how to use MHSA to most effectively provide services, but also how to comply with the mandates that are placed on them.

Commissioner Correa (who is also State Senator) thanked those who helped to defeat two of the propositions last May, one of which would have taken the money from Prop 63 to backfill the budget, and the other which dealt with the Prop 10 Children and Families Tobacco Tax money. The Legislature solved the budget deficit last February, but they thought the hole was \$42 billion. It was actually \$50 billion, because “every time you turn around you’re chasing revenues down.”

The Legislature must deal with less and less state revenue. After passing that budget, within a few days the state was \$8 billion in the hole. After May 19, when voters rejected Props C, D, and E, the hole grew by another \$7 billion.

Today, the budget deficit is at \$24 billion. The (Republican) governor proposed to eliminate Healthy Families, CalWorks, and Cal Grants; and he wants a \$4 billion reserve for “a rainy day.” The Democratic solution is to keep these programs and reduce but not eliminate them; then throw in some new revenues and bring down the governor’s rainy day reserve to about \$1 billion. There is currently a \$3-4 billion dollar hole to make up between \$21 billion and \$24 billion. That’s the challenge the Legislature now faces. A long-term challenge is that the state of California will continue to have declining revenues.

Commissioner Van Horn asked about the \$300 million MHSA payment to the counties that’s going to be moved from July 1 to August 1 -- will it remain a month in arrears as we go through the year. **Ms. Ryan** responded that the Administration has proposed, and the Conference Committee has approved, deferral to August of the \$300 million July MHSA payment to counties. There will then be a rolling one-month delay until the end of the fiscal year; so by June 2010 the \$300 million will be restored. Ms. Ryan suggested that the Commission keep an eye on the progress of the repayment.

Ms. Welch queried if a county is in a situation where cash is deferred and they have to borrow, who is responsible for the interest that the county must pay back to the funds they had to borrow to fill the gap in the missing MHSA cash?

Commissioner Pating remarked that at the Services Committee meeting they heard two concerns from county participants:

1. The delay in payments is significantly impacting services.
2. The willingness of the local communities and boards to give money back, with regard to statewide PEI efforts, is affected for the worse.

Commissioner Pating asked **Ms. Ryan** to clarify a worrisome issue: the reinterpretation of the maintenance of effort clause, which may place some MHSOAC money in jeopardy because of its impact on supplantation. She explained that a lawsuit was filed against the State regarding elimination of the AB 2034 program. A decision was rendered and the State won the judgment. Based on that judge's interpretation, the maintenance of effort requirement of the State was not program-by-program, but was in its entirety. Whatever the State was providing as far as local community services, as of FY 03-04, is what the State is obligated to provide pursuant to the MHSA.

There was a clear decision on the part of the legislature to go along with the judgment and the administration's proposals related to it. The administration decided that \$577 million is the state's obligation for funding community mental health services. However, they didn't pay attention to the policies of individual programs. Rather, they are backing into a total number, the \$577 million, and as far as the administration is concerned – and the legislature has indicated that they agree – there is a maintenance of effort of \$577 million for community mental health programs. That court decision is probably going to be appealed by the plaintiffs.

At the local level, there's only a certain amount of money to work with. There are obligations that you are required to comply with -- both state and federal law, and MHSA rules. Counties will need as much flexibility as possible, not to violate supplantation rules, but to make sure that the services funded through MHSA are eligible for funds. There must be recognition that for a variety of programs there is significantly less money at the local level to provide services.

Commissioner Correa emphasized that he needed to be part of this political process. Looking at the difference of \$3-4 billion between the two budget plans, with either plan that gets implemented, the ones who get hurt will be the poor. The ones who can least afford it are always the ones who get hammered.

Commissioner Prettyman voiced the concern that those affected by budget cuts need to know what to do. **Ms. Welch** responded that CMHDA recently met with NAMI presidents in Southern California; CMHDA has made a commitment to develop materials for their directors to share with their constituencies. The directors want to explain lower-cost methods for using

volunteers and traditional networks, like NAMI, to give more access to minimal resources. The signed budget may result in a lot of closed outpatient clinics. That's really the bottom line. The only silver lining is that it will force the development of more MHSA programs that meet the needs of people who don't need high-end FSP services.

Commissioner Correa remarked on the early prisoner release program that may be implemented without any backup services. Individuals with limited education, psychological issues, substance abuse issues, and maybe a lack of family support, are dropped back into the communities. The implication is that the burden is shifted to the county level. We'll have to become more efficient. **Commissioner Prettyman** commented that difficult situations can bring forth innovative ideas; and other Commissioners agreed.

Commissioner Gayle expressed his belief that veterans are worthy of additional support. **Commissioners Henning** and **Greene** agreed, and Commissioner Greene spoke of the 5% funds figure that can be made available for veteran services; a complication is that 22 different state agencies are all entitled to part of that 5%.

Chair Poat thanked **Commissioner Greene** for the budget report, gloomy as it was, and for assembling the massive amount of information.

5. MHSOAC Strategic Direction

Executive Director Whitt stated that three documents have been revised since the May meeting: the Strategic Plan, the Rules of Procedure, and the Communications Plan. All revisions have been done per the Commission's instructions.

Regarding the Rules of Procedure, **Commissioner Vega** proposed a maximum of two consecutive terms for the Executive Chair. He made a motion to that effect, seconded by **Commissioner Prettyman**. The vote will be taken after Public Comment.

Commissioner Correa described two Rules of Procedures issues brought to him by stakeholders. First, the Public Agenda notice of 10 days is insufficient time for stakeholders to distribute the information to constituents and receive their feedback; the stakeholders requested 30 days. Second, this same issue of insufficient time surfaced concerning the availability of Commission meeting materials. Stakeholders want more time to read and consider the materials and to express their views at the next meeting. Commissioner Correa suggested further discussion with stakeholders to establish a solution acceptable to them as well as the Commission. **Chair Poat** and **Executive Director Whitt** commented that extending the information distribution time would result in projects being held up for at least an additional month. **Commissioner Correa** requested taking 30 days to work on this question with staff and stakeholders and to reach a solution amenable to all.

Commissioner Van Horn remarked that they had a 6-month compilation of data on this subject, compiled with **Mr. Arnulfo Medina**, California Youth Empowerment Network and REMHDCO; this data will be considered as well.

Public Comment

- **Mr. Eric Zuniga**, MHSOAC Wellness & Recovery Center, distributed a letter about additional funding for the Wellness & Recovery Center for alternative mental health services. He stated that the letter was primarily based on input and directives from stakeholders who were enormously appreciative of this service.
- **Ms. Patricia Gainer**, specializing in client-led mental health services and mental health governance related to the MHSOAC, addressed the budget's negative impact on Wellness & Recovery Centers in Sacramento.
- **Ms. Dede Ranahan**, NAMI California, stated that the MHSOAC should model the stakeholder process that they want to happen at the local level. She addressed the 30-day time period for printed materials and the 30-day information period when a motion is presented for a vote. Stakeholders are feeling a real pushback with the reduction in public comment time, and the extra layer of involvement with the committees. Efficiency doesn't always equal efficacy.
- **Ms. Allison Homewood**, California Primary Care Association, thanked the staff for the language revision in the Rules of Procedure about committees and public comment: public comment at the committee level does not replace public comment at Commission meetings. Like **Ms. Ranahan**, Ms. Homewood supported Commissioner Correa's view that 10 days' notice is not sufficient.
- **Ms. Carmen Diaz** stated that the counties follow the 30 days' notice before approval rule with their own constituents; the Commission should follow it as well. She was disheartened that MHSOAC seems to be going backward, and she wondered which stakeholders the Commission is obtaining feedback from feel that 10 days is sufficient.
- **Mr. Medina** voiced the same concerns as **Ms. Diaz**. Counties are required to do a 30-day posting with public comment; to put the same time period in place for MHSOAC should be a non-issue. Counties want to know what's going on and 10 days only is just not working.
- **Mr. Anthony Carrillo**, MHSOAC Wellness & Recovery Center, felt that if an MHSOAC chairman is doing a good job, he should be able to serve as long as he wishes. Also, three years would be a good length for a term.
- **Mr. Jim Gilmer**, Services Committee, Cyrus Urban Interchurch Sustainability Network, and REMHDCO, stated that Commissioner Correa's 30-day proposal is well-deserving. From a committee member's standpoint, there's presently a slight disconnect in the information flow. Committees are the place for rigorous discussion, but right now MHSOAC is in the starting phases, and there are critical issues that deserve more time: to deliberate, to involve community stakeholders, and to build relationships across government and the community.

- **Stacie Hiramoto**, Racial and Ethnic Mental Health Disparities Coalition (REMDHCO), thanked the staff for including some of the recommendations that stakeholders offered at the last meeting, such as representation from ethnic and cultural communities on MHSOAC committees. She thanked Commissioners Correa and Van Horn for trying to accommodate the public and the consumers who need to give their feedback. Stakeholders are not trying to hold things up; sometimes eliciting their input at the outset of issue discussion will actually speed up the process.
- **Delphine Brody**, California Network of Mental Health Clients and MHSA Community Partners, strongly supported the inclusion of the 30 day time period into the Rules and Procedures. For chairs of committees, she requested that at least one chair be a client or family member; and that the Executive Committee include such members.
- **Ms. Marley** suggested that teleconferences may be a partial solution to the communication and notification issue.

***Motion** Commissioner Vega motioned; seconded by Commissioner Prettyman, that the Executive Chair will serve no more than two consecutive terms. . The vote was four in favor and eight opposed, and the motion failed.*

***Motion:** Upon motion by Commissioner Prettyman, seconded by Vice Chair Poaster, the Commission unanimously decided to Adopt the Rules of Procedure with the exception of the 30 day document notification and the Executive Committee discussion.*

6. **Closed Session**

The Commission met in closed session pursuant to Government Code Section 11126(a)(1).

7. **MHSOAC Strategic Direction, #4: AB 5xxx**

Ms. Beverly Whitcomb, MHSOAC Staff, clarified the definition of MHSOAC staff's role according to AB 5xxx. There are five components:

1. The key functions of current operations.
2. The current method for achieving them.
3. Recommendations on how to proceed with current operations, or amended procedures authorized by AB 5xxx.
4. MHSOAC's budget implications.
5. A suggested timeline.

Administrative duties currently performed by DMH need to be performed by an entity other than DMH, so DMH and MHSOAC remain "separate and apart," the key phrase in the

MHSA Section 5845 amendment. The staff recommended contracting out with another state entity, to perform the functions that are currently administered by DMH. Staff would like to have the authority, as they grow and gain expertise, to assume these duties in-house. Eventually, these MHSOAC administrative functions will be completed in-house (within 3-5 years).

Staff discussed the term “separate and apart” with their legal counsel, which recommended that they be assigned a separate organizational code from DMH, in order to comply with AB 5xxx.

Mr. Jim Alves, Health and Human Services Agency, further explained compliance with AB 5xxx. MHSOAC is now funded through a program within DMH’s budget, and DMH also does all the HR functions and contracting. To achieve compliance, the best method is to create a separate organizational code equivalent to the code that other state councils and commissions use. He supported the staff’s recommendation to contract out with another state entity to perform those functions currently administered by DMH.

Ms. Whitcomb closed by stating that having its own code means that MHSOAC staff will receive a direct appropriation in the budget. Health and Human Services Agency needs to have a discussion with DMH about how staff will be able to request additional funds.

Chair Poat asked how MHSOAC gets the most effectiveness out of each MHSA dollar, remembering that administration is not what citizens voted for; obviously, they want services to be flowing out the door. Policy independence is most important in his view, and the Commission needs the staff capacity to make its own independently reasoned decisions.

Discussion ensued about policy, budget allotment and independence.

***Motion:** Be it resolved that the MHSOAC affirms its policy independence, which includes but is not limited to the capacity to perform policy, regulatory, legislative, legal, and administrative functions. Independence will be achieved through a combination of interagency agreements, contracts and internal resources. Staff will develop a Business Plan in July which will identify how the MHSOAC’s infrastructure will be developed to secure ongoing autonomy and alignment with AB 5xxx. The motion passed unanimously.*

8. Adopt Stigma and Discrimination Strategic Plan

Dr. Stephen Mayberg, DMH Director, began by first addressing the pressing topic of the prudent reserve:

DMH is in the final phases of completing its Information Notice about prudent reserve. Three important points:

1. We are proposing that any funds set aside for PEI that have not been expended can be used for prudent reserve.

2. We have calculated that we will trigger activation of the prudent reserve in FY 10/11, based on the 3-year average.
3. Most important: Once we've triggered the prudent reserve, we need to revisit the questions: What are the requirements for the contents of a prudent reserve? How do we get money into the prudent reserve?

He then turned to the topic of the Stigma and Discrimination Strategic Plan. The plan is very similar to the Suicide Prevention Plan in that it embodies the ways the community can develop a strategic document. That has relevance not only to how the MHSA is implemented in California, but also to how it's already getting national attention. The Stigma and Discrimination Plan is dynamic rather than static -- as we learn more, the document will be changed and amended.

Ms. Barbara Marquez, DMH Stigma and Discrimination Reduction Unit, presented the Plan outline.

The Vision Statement: *"We envision physical and mental wellness for all Californians, and a future where mental health labeling, stereotyping, and discrimination belongs to the past. We envision a future where people affected by mental health challenges are socially included, valued, and supported in their wellness and recovery, education, housing, employment, health care, and other needs, in order to live a fulfilling and productive life. The vision of mental health wellness will emerge through raising awareness, education, and concerted efforts at all levels."*

Highlights of the Stigma and Discrimination Strategic Plan:

- It is a 10-year plan targeted to all of California.
- It is guided by the MHSA, DMH, MHSOAC, and the counties, as well as the public and private sector, including landlords, employers, and others.
- It is a roadmap and it is dynamic. Over the next 10 years we will reflect on it and reassess it.
- It is a resource and a guidance document.
- It is reflective of the MHSA. Core principles speak exactly to Prop 63.
- It is focused on both stigma and discrimination.
- It builds on the strengths and opportunities that exist in California, through the work being done through the MHSA and other venues.
- It is a partnership, developed with the help of many, including Commissioners Vega and Prettyman.

Mr. Jordan Blair, a doctoral student working with DMH, then gave a summary of the plan's development. In May 2008, MHSOAC requested that DMH develop the plan. DMH used a very inclusive process, consulting 52 advisors and holding two public workshops and a statewide participatory conference call. DMH had a vision, in addition to the core principles, that will affect future direction, actions, and next steps. The six core principles are:

1. To implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations.
2. To employ a lifespan approach to effectively meet the needs of different age groups.
3. To involve a broad spectrum of the public, including mental health consumers, family members, friends, caregivers, mental health and allied professionals, advocates, and agencies that interact with children, youth, adults, and older adults.
4. To address all types of stigma and anti-discrimination laws.
5. To build upon promising practices and proven models.
6. To recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery.

Mr. Blair then cited the strategic directions of the plan and pointed out the 26 recommended actions, which include 118 next steps that measure implementation.

Commissioner Vega noted that stigma and discrimination isn't well understood beyond a superficial level. He gave illustrations of three individuals and the difficulties that they experience because of mental illness stigma.

Mr. Richard Krzyzanowski of the Orange County Stigma Elimination Task Force described his firsthand experience with self-stigma; and how you can become your own worst enemy and obstacle to recovery. Sometimes the stigma within the mental health community, and specifically the professional mental health community of service providers, is stiff and difficult to deal with.

Public Comment

- **Mr. Zuniga** commended all those who worked on the plan. To help in making it something tangible that people can sink their teeth into, he made himself available and distributed a letter to the Commissioners.
- **Ms. Brophy** supported adoption of the plan. Although the process moved too quickly for the concerns of clients to be adequately addressed, DMH did make a great deal of effort to incorporate stakeholder comments. She stated that 10 years is too long a time for a resource document of this importance -- on a topic of this complexity, on which new research is frequently being introduced -- to stand without updates. Updates are needed at a minimum of 3-year intervals, informed by a

comparably robust stakeholder process. Also, she reported that **Mr. Steve Leoni** respectfully asked that his name be removed as an author in the introductory quote.

- **Ms. Welch** also thanked DMH for completing the plan, especially under the circumstances. She commented that today's message was important; and that using the programs Mr. Krzyzanowski referred to can empower people to get involved and educate the community about mental health issues. She encouraged creative thinking in these tough fiscal times, and to use MHSA resources to fill the gaps that are going to exist in the next 3 years.

She then asked for confirmation from Dr. Mayberg that DMH is moving forward with utilizing \$10 million per year over the next 4 years to implement the Suicide Strategic Plan, so that the good work for the Stigma and Discrimination Strategic Plan will also be considered for funding, etc. **Dr. Mayberg** responded that these two plans are indeed critically important, and all possible funding is necessary to move them forward.

- **Ms. Marley** suggested that NAMI provide an educational DVD on the subject of stigma reduction for all high school seniors.

***Motion:** Following the motion of Commissioner Vega, the Commission voted unanimously to adopt the Stigma and Discrimination Strategic Plan.*

9. PEI Plan Approval: Butte County

Ms. Ann Collentine, MHSOAC Staff, presented the Butte County PEI Plan, commended its contents, and recommended it for approval.

***Motion:** Upon motion by Commissioner Henning, seconded by Commissioner Gould, the Butte County PEI Plan was unanimously approved.*

10. Presentation: Survey of State Sheriffs and Mental Health Directors Regarding MHSA Planning

Commissioner Kolender introduced the presentation. He remarked that, as a sheriff for many years, he has dealt with the relationship between the criminal justice system and the mental health system. He has watched the cycle in which people are arrested, go to jail or prison, go to a hospital, are released, and are arrested again. The State needs to address the ongoing problem of mentally ill offenders.

Mr. Richard Conklin of the San Diego Sheriffs Department gave a PowerPoint presentation on the survey. Its purpose was to raise the awareness between law enforcement and mental health directors about the MHSA, and to increase mutual understanding and joint participation. Highlights included:

- The survey related to the Strategic Plan in that it addressed “the transformation of the California community-based mental health system.”
- Among the negative outcomes of mental illness are incarceration and homelessness. In the criminal justice system, these are two sentinel events that are constant and increasing.
- People with co-occurring disorders have disproportionately large numbers of arrests and homelessness.
- Other key findings: funding is disproportionately low; co-occurring disorders are disabling; and Full Service Partnerships (FSPs) are needed to provide integrated care.
- Veterans are increasingly involved in the criminal justice system as a result of insufficient services.
- County sheriffs were asked about their knowledge of the MHSA and local mental health services, while county mental health directors were asked about law enforcement’s involvement in local mental health. Their answers were compared.

Ms. Welch described a program in Kern County that exemplified the partnership between criminal justice/law enforcement and public mental health. Kern County turned a mentally ill offender crime reduction program into an FSP program that has served about 90 people for two years. The majority of the clientele is male with a co-occurring disorder, and they are re-entering the community. The program’s reasons for success are that it gives clients educational and employment skills, as well as housing; and it has created a partnership between the sheriffs department staff, the mental health department staff, and consumers/family members. The program has resulted in a cost savings to the county of \$540,000/year on average.

***Motion:** Commissioner Pating motioned for the Commission to direct the Services Committee to continue to seek opportunities to partner with the law enforcement community and the judicial community to further the goals of MHSA. Vice Chair Poaster moved for the motion; Commissioner Vega seconded. The motion passed unanimously.*

11. Honor Sheriff Kolender

On behalf of the Commission, **Commissioner Gould** presented a Joint Member Resolution from the Legislature to honor **Sheriff Kolender** for his work as a Commissioner and his many other career accomplishments. Sheriff Kolender was particularly recognized for bringing mental health issues into the law enforcement community. Highlights of his law enforcement career include:

- He became the 28th Sheriff of San Diego County in 1995, and was re-elected three times.
- He ran the three main services: Law Enforcement, Detentions, and the Courts.

- He served as the San Diego Chief of Police for thirteen years. At age 40, he was the youngest Police Chief in the nation.
- He and his wife Lois founded the San Diego Psychiatric Hospital Auxiliary by creating an endowment for them.

Sheriff Kolender expressed his heartfelt thanks.

12. Adopt Recommendations from Client and Family Leadership Committee (CFLC) Regarding the DMH Interim Issue Resolution Process (IRP)

Commissioner Prettyman provided the background for the recommendations. A workgroup met for ten months to advise DMH on the development of a procedure for responding to MHSA-related issues and DMH is receiving input from stakeholders regarding the draft IRP. Issues regarding the interim IRP include:

- The effectiveness of current approaches to issue resolution is unclear.
- There has been no systematic inquiry of client and family members regarding their perception of the effectiveness of existing mechanisms.
- Lack of understanding about how and where issues may be addressed is an acknowledged source of confusion to many stakeholders.
- Clients, family members and representatives of publicly funded programs are often reluctant to complain for fear of reprisal.

She noted that these issues are not in line with MHSOAC's values of inclusivity, respect and trust, objectivity and autonomy, transparency, and freedom from fear of retaliation.

Commissioner Vega remarked that the CFLC responded to the proposed process within the frame of MHSOAC's expertise. CFLC has two key recommendations:

1. That the Commission convene a workgroup, consisting of designated co-chairs and representatives of the CFLC, the Services Committee and the Cultural and Linguistic Competency Committee, to develop recommendations regarding statewide issue resolutions processes, using the CFLC's recommendations as a discussion starting point. The workgroup will report its recommendations to the Commission in October 2009.
2. The Commission will ask DMH to provide a quarterly summary of issues and their resolutions. CFLC will provide annual reports and recommendations in response to DMH's report.

Much discussion ensued. **Commissioner Vega** offered to take the role of point person as the workgroup develops its recommendations for DMH. The workgroup will bring the recommendations to the full Commission in October 2009.

13. The Executive Committee Charter

Chair Poat read the proposed language for the Executive Committee Charter: its outcomes, scope, membership, and purpose. However, due to the late hour, the Commission lacked a quorum and the vote was postponed.

14. General Public Comment

- **Ms. Hiramoto** stated that REMHDCO recommended that clients, family members, and cultural communities be represented on the Hiring Committee; and that at least one member of the cultural community be on the Interviewing and Selection Committee.
- **Mr. Zuniga** again stated that stakeholders anticipate MHSA-funded plans be transformative and innovative. The MHSA Wellness & Recovery Center is expanding dramatically to take into consideration a lot of the changes happening in the county. He also took the time to quell three rumors:
 1. The Center is transparent about consumer self-help and the services it provides. Family members and consumers provide input at every level.
 2. It is a wellness provider. Its goal, along with MHSA, is to provide services that lead to profound transformation.
 3. It's services are not underutilized, and it is accomplishing cost savings.

15. Adjournment

Chair Poat adjourned the meeting at 5:02 p.m.