DRAFT

MHSOAC

Mental Health Services Oversight and Accountability Commission
Meeting Minutes
October 22, 2009

Hilton Oakland Airport
One Hegenberger Road, Ballroom IV
Oakland, CA 94621

1. Call to Order

Chair Andrew Poat called the meeting to order at 1:28 p.m. He noted that the Commission had been meeting in Closed Session to discuss filling the currently open position of Executive Director.

Chair Poat acknowledged the work of **Commissioner Tom Greene**, who is leaving the Commission, effective immediately, after accepting a position to work in Washington, D.C. In addition, two other Commissioners will be moving on: **Linford Gayle** and **Darlene Prettyman** will be leaving in January. He thanked the Commissioners for their work with the Commission.

2. Roll Call

Commissioners in attendance: Andrew Poat, Chair; Larry Poaster, Vice Chair; Richard Bray, Lou Correa, Linford Gayle, Beth Gould, Mary Hayashi, Patrick Henning, Howard Kahn, Darlene Prettyman, Larry Trujillo, and Richard Van Horn.

Twelve members were present and a quorum was established.

3. Adoption of September 2009 Meeting Minutes

MOTION: *Upon motion by Commissioner Poaster, seconded by Commissioner Bray, the Commission unanimously adopted the September 2009 Meeting Minutes.*

4. MHSOAC Performance Dashboard, October 2009

Chair Poat thanked the staff for the continuing improvement of the Dashboard, and for the cooperation of the Department of Mental Health (DMH).

Chair Poat remarked that the key question before the Commission now is on the status of the regulations – where we are, and why we are where we are.

Interim Executive Director Beverly Whitcomb stated that DMH puts out an annual rulemaking calendar but thus far OAC has not been able to get the dates for the 2010 calendar. **Ms. Filomena Yeroshek**, Staff Legal Counsel, remarked that some progress

has been made regarding the Innovation and PEI regulations, which is exciting to see. Also, she has been requesting the status of the regulations on a weekly basis.

5. Presentation on the California Mental Health Services Authority

Mr. Allan Rawland, California Mental Health Services Authority (CalMHSA) President, and Director of Behavioral Health, San Diego County, introduced the presenters: Mr. Mike Oprendek, CalMHSA Vice President; Mr. Curtis Boewer, CalMHSA Trasurer, and Mr. John Chaquica, President of the George Hills Company, Inc.

Mr. John Chaquica, George Hills Company President and JPA Manager, began the presentation by noting that the George Hills Company represents about half of California's counties as a third-party administrator. They are the acting and managing firm for the JPA, and manage several hundreds of millions of dollars in that capacity.

The definition of a JPA is "*an institution permitted under law, Section 6500 of the Government Code, whereby two or more public authorities* (e.g., local governments) *can operate collectively.*"

The main goals of a JPA are to establish fiscal efficiencies and enhanced delivery of services.

JPAs are characterized as separate, distinct governance from member counties. It derives its powers from the participating agencies and can employ or contract independent staff to carry out and implement board policies.

Mr. Rawland provided some additional information on JPAs:

- The JPA has a separate Board of Directors and Executive Committee and is approved by a Board of Supervisors. The Executive Committee is made up of JPA officers and regional representatives.

- It has separate legal counsel.

- It involves all the major stakeholders and strategic partners, as well as the various service providers.

- This particular JPA's values are very consistent with how they view the MHSA and how they view mental health. It is very transparent and inclusive and encourages collaboration and participation. It will be flexible, dynamic, scalable and accountable for results. Thus far, it has been working in six counties, on a number of projects.

- Most recently, the workforce education and training monies were allocated to the respective regions and those regions were able to put together an MOU that allows the JPA to manage $1.8 million over the next three years.

- JPAs are not a legislative agency setting codes and regulations. It is an administrative fiscal mechanism and entity.

- It is not an advocacy body; rather, it works under the auspices of its' respective Boards of Supervisors.

- It is not an approval body and is not involved with the approval process in regards to the MHSA.

- It is not an organization with limited capacity and capability; it can use a variety of resources.

- It will not limit potential service providers.

The CalMHSA-JPA Agreement/Purpose includes such programs as addressing suicide prevention and ethnic/cultural outreach; stigma/discrimination reduction related to mental illness; student mental health/workforce training and education; training, technical assistance, and capacity building; and may provide other necessary administrative services.

Mr. Curtis Boewer, CalMHSA Treasurer, discussed the history of this JPA, which culminated with the JPA Agreement that was signed on July 9, 2009. Eight counties have joined thus far; thirty counties are showing interest in joining; and about 21 counties are in process.

This JPA structure is established: the administrative firm and legal counsel have been hired and strategic planning sessions held, a budget developed, and a banking/financial system is in place.

Mr. Mike Oprendek, CalMHSA Vice President, stated that they are working with DMH now in drafting an MOU. A recent survey confirmed that the JPA's future is on track, with 79% of responding counties considering membership, 43% currently reviewing with their mental health departments; and 36% reviewing with their county counsel.

Chair Poat remarked that the presentation shows how money will actually get out onto the streets to provide the services that are so necessary. He thanked the entire CalMHSA team for helping to make that happen.

Mr. Rawland stated that the JPA is real and moving forward with capacity-building and technical assistance. It is engaged with DMH regarding the MOU and working through the remaining barriers. The collaboration and communication is wide open.

Commissioner Henning asked about the costs associated with the JPA. **Mr. Rawland** responded that George Hills Company is on a $5,000 monthly compensation package, which increases to $7,500 a month when dollars start coming in to the JPA. The current contract is an annual commitment. The legal contract is separate from the contract with George Hills Company; currently, the law firm is billing on an hourly basis. He stated that, in his experience of over 20 years, he has never seen a JPA disband; rather, it merges in with another JPA. **Mr. Chaquica** added that the JPA is time-limited but the concept of the JPA can be used for efficiencies beyond the statewide projects.

Commissioner Henning suggested that the Commission needs to really look closely at projects as they are administered; the introduction of a JPA has now changed considerably from the way administration was initially envisioned. He cautioned that the Commission needs to continue to take a strong look at its guidelines as it moves forward.

Commissioner Prettyman asked about the accountability of the JPA itself.

Mr. Rawlands replied that the JPA itself; i.e., its board members, have the responsibility for accountability. George Hills Company does the accounting and is responsible for that. All JPA meeting agendas fall under the Brown Act and are thus open to the public. Its monthly Minutes are on their website.

JPAs are required to have an annual report submitted to the State Controllers Office. From an internal standpoint, the accounting is already established, the financial statements will be open to the public, and monthly reports will be prepared and go to the Treasurer's Office as well as be available to the public.

Vice Chair Poaster commented that the JPA is a mechanism that is being put together to implement the $160 million. The JPA will receive the money from the counties and contract with the appropriate entities to do whatever additional planning is needed to make these programs implementable.

Mr. Chaquica added that the approval of projects goes through the OAC. Any project will still need to go through the OAC for review and approval and would have to meet the guidelines. Once approved, it would then be implemented and be subject to all the appropriate reporting requirements of any other MHSA service.

Commissioner Correa suggested that it might be helpful for the Commission to receive monthly reports on JPA activities. **Mr. Rawland** responded that they would be happy to provide reports.

Commissioner Hayashi asked if there is a sunset date for the JPA? **Mr. Rawland** said there is none.

6. Report from Mental Health Services Committee: Adopt PEI Statewide Program Guidelines -- First Read

Commissioner Gould, Co-Chair of the Services Committee, stated that the PEI Guidelines require Commission approval prior to implementation. She cautioned Commissioners to be mindful that the Commission is not reinventing these projects; rather, they are simply implementing projects that have already been conceived and approved.

Carol Hood, MHSOAC retired annuitant, provided some of the history of the draft Guidelines. She reiterated their objective, which is to issue Guidelines that provide clear direction and a streamlined process to counties to request and receive approval of funds for the three PEI statewide projects (Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health); and to reflect the values and principles adopted by the MHSOAC regarding the three statewide projects.

She referenced the strong consensus within the Commission that the Guidelines have a streamlined process consistent with the approved timeline. After today's first read of the draft Guidelines, next steps will be a second read and possible adoption at the November 2009 meeting, followed by possible issuance of the Guidelines in December 2009.

Guidelines provide direction to counties regarding their local MHSA plan and include any essential, additional direction regarding allowable uses of funding, content requirements and submission procedures. They also provide the standards for DMH review and MHSOAC approval and begin to set the framework for evaluation.

The draft Guidelines Summary of Contents includes:

- An Executive Summary;
- Background – history, core values and context;
- Allowable uses of PEI statewide project funds (the rules); and
- Content and format to request funding.

Counties have choices to participate in statewide projects. Some counties have assigned funds to DMH; some provide funding to a JPA or statewide entity or to other multi-county collaborations. Also, replicable projects could be done, to learn from local/regional/multi-county projects, so they may be implemented statewide later on.

The best case scenario timeline for Guideline implementation is:

- Guidelines approved for issuance – December 2009.
- County receives input, completes funding request/plan and completes 30-day local review, submits plan to DMH/MHSOAC – February 2010.
- DMH reviews/MHSOAC approves, MHSA Agreement Modification – March 2010.
- Funding provided to county – April 2010.

Ms. Hood discussed some of the process involved with suggested revisions to the plan requirements that came out of the Committee meetings. She also answered Commissioner's questions about specific suggested revisions.

One specific potential revision concerned a policy direction requested for the community planning process funding, and has two options:

Option 1 – Establish a new separate process for approval and distribution of planning funding prior to plan submission.

Option 2 – Planning and stakeholder involvement are allowable costs.

She concluded by suggesting that the Commission adopt a one-week written public comment period for responses to the draft Guidelines.

Public Comment

- **Ms. Donna Barry**, Client/Family Leadership Committee (CFLC) member, stated that she had concerns about the amount of time allowed for response to this proposed motion (i.e. the one-week public comment period). The more standardized 30-day response time should be used.

  In terms of a JPA – having a third party, George Hills Company, is problematic, because stakeholders may no longer have control or input on how the funds are going to be implemented. It could be someone from another state or country implementing the contracts, and this is a concern.

  Administrative costs for JPA – 5% of the allocated $160 million is $9 million. Nine million dollars could support several programs. A small program may cost $200,000 to fund. The $9 million amount seems ridiculous and those costs should be significantly reduced.

- **Ms. Dorothy Frieberg**, Senior Peer Counselor, Sonoma County, began by acknowledging that she has benefitted tremendously from the California Network of Mental Health Clients and the MHSA money – it got her back and working in the community.

  She stated that the same overworked case workers that have already been hired should not be used for this, except for getting referrals to MHSA programs.

  The money should not be used to fill the gaps exposed by mental health "cutbacks" in all the counties.

  The money should not be used to hire persons already receiving state retirement benefits. Instead, hire competent people who are not double-dipping. There are many competent unemployed people who need jobs, too.

  The money should be used for innovative approaches to mental healing, rather than the "same old same old" of drugging our clients, locking them up, and, more recently, tazaring them.

- **Ms. Lisle Boomer**, Alameda County Suicide Prevention Plan Advisory Committee member, addressed several points that her committee had raised:

  It was always questioned when and how the plan would be enacted and if we would have any opportunity for involvement. This was a concern of probably 75% of the Committee. How can we be involved and when will the money come out?

  We were told that there would be an office for suicide prevention that will be in charge. To date we haven't seen anything done by this office except hold the plan hostage. They don't want to mail the plans out. I've asked for plans so I can distribute them in Alameda County and they don't want to send them to people; rather, they want to send a summary only.

  So, while we wait for the OAC to come up with a way to distribute these statewide funds, people are actually dying. I don't know the right answer; but I know that, while we are sitting here waiting for the decisions to be made, it seems like there isn't a way yet that will work.

  Alameda County left out suicide prevention in its PEI plan because we thought the statewide project would cover it, and now I'm learning that the statewide projects never had any funding because it was actually with the counties. Maybe I'm incorrect in that but I'm just trying to figure out what is going on. Where are those funds and why are we still watching people die in this area?

Chair Poat remarked that he believes the Commission can answer those questions and the JPA is needed to roll these programs out.

- **Ms. Cheryl Maxson**, Modoc County, stated that one issue with the JPA is that they said they handled small counties all the way up to Shasta. What about Siskiyou, Modoc and Del Norte? I didn't hear any mention of them. How can we participate if we're not even on the list?

  Also, I would like to firmly stress that Option 2 of the potential revisions ("Planning and stakeholder involvement are allowable costs") should be approved and there should be travel advances for those who are furthest away. We have been waiting for over a year for our per diems. I am taking money out of my grocery bill to be here and I have no inkling about when I'm going to get a penny of that back and it has been over a year. Allowable costs need to be budgeted and distributed.

Commissioner Kahn requested that a report be made available, perhaps at the next Commission Meeting, on what kind of time is outstanding for expense reimbursements for the representatives.

- **Ms. Stephanie Welch**, California Mental Health Directors Association (CMHDA), first stated that they support and acknowledge that the Commission is doing what it can, within the Guideline structure, to encourage counties to use the JPA or another statewide entity in order to quickly implement these projects.

  That being said, she is struggling with Options 1 and 2. The Act does have allowable use of costs. However, in stating that these are allowable costs -- if counties are allowed to use other PEI funds, as those funds are subsumed under the Guidelines for this purpose, then they can be "paid back for" -- if that is a possibility, then we would be in support of Option 2. If counties with approved PEI plans can then use some of those funds for any plan they may need, up to the allowable five percent, and then pay themselves back once they are acting as part of an approved plan, then I don't see any problem with Option 2 going forward.

- **Ms. Delphine Brody**, California Network of Mental Health Clients, stated that they have been struggling with the complexities of the financing in the guidelines. Also, it does seem premature to set the timeline for public comment at one week. Please allow at least 30 days for the public to consider these proposals.

Chair Poat described the decision before the Commission regarding public comment timelines – we want to allow adequate comment, but it is also imperative that we get the funding out.

Commissioner Henning clarified that this process is not closing off public comment. This is not yet a final document; the time periods we are discussing today reflect the closing of the first read portion of the process only. Public comment will remain active.

Commissioner Gould remarked that they want to encourage as much input as they can get, as soon as possible. There is another Services Committee meeting on November 4th, where this topic will be discussed.

Ms. Hood further clarified that Option 1 is to set up a new process where counties can submit a request for up to five percent of the PEI statewide funding for community planning processes. That request would be submitted, looked at and approved, the MHSA agreement modified, and a check would go out to the county to provide the additional funding. This would be for the five percent planning monies only.

Commissioner Henning suggested that, as dialogue on the two options is ongoing, perhaps this motion should be continued until November. **Chair Poat** agreed.

Vice Chair Poaster commented that Option 1 was not consistent with the idea of setting up incentives so that the counties would join and continue in the development of the statewide project.

After further discussion, it was decided to postpone the motion to the November meeting.

7. Consider Recommendations from Client and Family Leadership Committee on the Public Comment Process – Second Read - *Postponed*

8. PEI and Innovation (INN) Plan Approval/Status Update

Mr. Clark Marshall, MHSOAC staff, discussed two county plans that were being submitted for Commission approval:

Sacramento County: recommended approval amount of $1,600,000.

Ventura County: recommended approval amount of $5,250,583.

There were also three status updates: Lake County (PEI Plan), and Monterey and Trinity Counties (both INN plans) are all actively engaged in completing the process.

Public Comment

- **Mr. Marv King**, Business Solutions Associates, recommended approval of the Ventura County project.

- **Ms. Susan Kelly**, MHSA Coordinator, Ventura County, stated that the plan presented today by their county is representative of the stakeholders of the county. She thanked the Commission for its time.

- **Dr. Gabino Aguirre**, Ventura County Behavioral Health, remarked on how pleased he was with the recommendation and urged the Commission to approve the proposal. They are anxious to move forward with the project.

MOTION: *Upon motion by Commissioner Van Horn, seconded by Commissioner Henning, the Commissioner unanimously approved the Sacramento and Ventura County plans.*

Mr. Marshall noted that the OAC has now approved 47 plans totaling $327,550,012.

9. Cultural Competency Training

Commissioner Van Horn, Cultural and Linguistic Competence Committee Chair, led the training. He gave a slideshow that discussed health disparities in the state. Some highlights:

- California has the most culturally diverse population in the world.

- In terms of race and ethnicity in California, from 1970 to 2000 the population shares were:

  - "Anglos" reduced from about 78% to about 48%.

  - Latinos rose from about 11% to about 28%.

  - The Asian/other classification went from about 4% to 10%.

  - African-American stayed at about 8%.

- In 2000 a "multi-racial" category was entered into the US Census.

- From 2000 to 2050 the projected California population shares are:

  - Anglos – about 24%.

  - Latinos – about 52%.

  - Asians and African-American populations stay about the same.

  - The new "multi-racial" population will be about 10%.

- These changes are expected to reflect a growth in population of new Americans; i.e., will be driven by immigration and naturalization rather than movement away from California.

- There is a tremendous diversity within these population groups that may require adding new groupings over time.

- For Native Americans, a large majority are not served by the Indian Health Services, as they primarily live in urban areas.

- There are huge disparities in mental health care in different populations. About half a million children in California live in foster care and somewhere between 40-80% have mental health issues. This is especially problematic for the very young children in foster care.

- Child poverty is higher in rural areas, especially among minority populations. Over 40% of African-American, Native American, and Latino children live in poverty.

- Disparities in health care are growing, not shrinking, especially for poor populations.

- Needs include:

  - To increase awareness of racial and ethnic disparities in health care.

  - To collect patient data by race and ethnicity, rather than simply observational reports.

  - To include race and ethnicity in our performance measurements.

  - To promote the use of interpretation services until we have a culturally competent workforce.

  - To increase the diversity of healthcare workers so we don't have to depend on translators.

  - To integrate cross-cultural education into the training of all current and future health professionals.

- Culturally competent care is compatible with culture and language. It recruits and retrains both staff and leadership. It has ongoing education and training in culturally and linguistically appropriate services.

- Language assistance must be available at all points of contact and during all hours of operation. Easily available and understandable patient-related materials and signage in the client's language is important.

- The key elements in addressing and reducing disparities in the planning process are daily utilization of quality improvements; adaptations in services and support to address the needs of underserved communities; the building of a better infrastructure that targets training and technical assistance; frame our messages so that they impact the people in California; and to champion alliance and coalition building.

- We don't have the knowledge of what the term "multi-racial" really means; nor do we have that knowledge in terms of our state data systems.

Commissioner Kahn remarked that asking people to self-identify on their documentation seems to be effective in acquiring specific data.

Commissioner Trujillo asked why Muslims were addressed by the Committee – isn't that a religion? **Commissioner Van Horn** responded that it is a religion, and it is also a culture. In addition, this has been an area of major concern in the country, especially following the events of 9/11.

(A short video highlighting Native American mental health issues was shown.)

Ms. Janet King, Native American Health Center, Project Director and member of the Cultural and Linguistic Competence Committee thanked the Commission for attending the recent Talking Circle at the Native American Health Center. She noted that the Native American community does not fragment their community into categories of client, consumer, family member, provider, etc. They are all community members and thus are in all of those categories simultaneously. As a continuation of the Cultural Competence Training, Ms. King introduced the following individuals from the Native American Health Center:

- **Ms. Paula Marie Parker** commented that she feels "a little pissed off." Why is the Commission considering shortening the amount of comment time? It has already been moved to the end of the day. There was a full room when the meeting first started and now a lot of people have trickled out. One wonders if Commissions like this one are really about their business or if it's a big charade. It's very hard to listen for six to eight hours. We took time off from work and jobs to come here.

  I am African-American with Native American ancestry. I have a twin brother who is a mental health recipient in a rural Napa County facility called Crestwood Anglin (?). I have watched his journey and it's like a big monopoly game. I watch my brother either go to prison, or sometimes he gets out of jail and runs

away; sometimes he's in a mental facility; sometimes he's homeless. He's been all over the map. I'm speaking for him because he can't be here.

Cultural relevancy in mental health is everything. People of different cultures feel some things that those of other cultures just don't understand. Is it impossible to find therapists of Native American ancestry? I know it's very hard, as a woman of color, to sit across from a white male therapist and bear my soul, especially after being out in the workforce for 30-40 years battling a lot of people who look like him. They are not all bad people, but it's still hard to look at him emotionally and mentally.

My prayer would be that we could find more people, more trained therapists, who are Native American, African-American, Latino or Asian, to staff centers that deliver services to those segments of the community.

Also, I attend Laney College and am a retired journalist. It's a sad commentary that most Native Americans have disappeared. For example, I recruited with Laney College for awhile and discovered that they don't recruit Native Americans, even though downtown Oakland (where the college is located) has a large Native American population.

How far do we need to "drill down" on some of these statistics? We need to drill all the way down. When "Native American" is now categorized as "Other", whatever that is, we have a big problem.

As a client of the Native American Center I've been involved with a women's group that means a lot to me. We sit and talk about what we've been struggling with. We do art projects.

It's important for me to process some of the "stuff," the pain and rage that's still there from being stomped on and disappeared. As a reporter I covered many a hearing that bored me to tears but, because I had to be there and write about it, I had to keep awake. I just ask people – we all need to be awake.

- **Ms. Sheila Jumping Bull** asked for the Commission's full attention, as she has given that to them. She expressed how tired she was to be disrespected as a Native American person.

  We need our facilities because it's the only place we have to go for our understanding and our trust. I can't look at you and say to you "this is what's wrong with me" because you guys won't understand and say "okay, go pray" or "go to the ocean."

All we have is our Native American facility, and there's only two. Little by little, every year, the budget gets cut. What do you get out of taking from the Native American community when we've been took from all these years?

The mental health services means a lot to a lot of natives. Thank you to those of you who do pay attention and to the rest of you, one day it might be a Native American person that you come to for help and we might be the ones that can give you the answer.

- **Mr. Ethan Nebelkopf,** Director of Mental Health, Native American Health Center, thanked the Commission for putting this issue on the agenda and having the patience to listen to what the community members are saying. He also thanked the audience members for being here and expressing their true feelings.

He has worked at the Center for 12 years. He believes that mental health services has gone onto the wrong track. The way the insurance is, the way that medications are dispensed, the way resources are distributed and funded, is really out of whack.

The MHSA is a method for restoring balance. This is something I learned from the Native American culture. A true and effective mental health system has to acknowledge how mental health and mental illness is perceived in each cultural group. The basic domination by white psychologists to define what it is and how the resources are developed needs to be changed. That's why it's so important to reduce disparities.

The Native American Health Center was chosen to represent the Native American voice in California. What we have been saying -- that there are age-old techniques of restoring balance and achieving mental health -- are not recognized in mainstream psychology. The acknowledgment in the state of California by DMH and the Commission that these cultural methods of healing are valid, is very, very important: Talking Circles, traditional consultants --.

In the news recently there's been a lot about sweat lodges. What's in the news was a tragic event; but it was exploitation by non-Indian people, done the wrong way, and that's why it was a tragedy.

The people here are dedicated to presenting information so that you can understand and acknowledge and support resources to develop an indigenous psychology, an indigenous system of healing for Native Americans, for people of color, for all different ethnic groups, that are developed by and for these cultural groups. Thank you for taking the time to listen to us and hear what we've been hearing each and every day.

- **Mr. Dan Blue Wolf Watches** stated that he fits into two cultural boxes – Cherokee and Chinese. He was adopted by a white, prejudiced family and, growing up, was never able to be amongst his people of either side. Every history book seems to talk about the Jewish people being wiped out by the millions; about how blacks were enslaved. It talks about all these cultures that have been destroyed but hardly ever is there anything about a Native American.

  When I got back to my roots I didn't trust a lot of white people. The Native American Health Center is important to me, not only for me but for the younger generations that are afraid to admit that they are Native American, because they get teased, picked on, beat up, and whatever. For me it's the best way to get help for everything that I've been through.

  Does a cancer patient go to the dentist to get the help they need? Being a Native American, I can't go to somebody for help that I don't trust. Being among my own people, they know what I've been through and they can help me.

- **Mr. Dean Jeff** stated that the people at the Center have been helping him. When you are down and out they will take care of you. At other places they say "no, you've got no Blue Cross, you've got no Medicare." These people take me in and help me.

- **Ms. Annie Mora** thanked the Commission for having them there today.

- **Mr. Mike Raccoon Eyes**, a Cherokee and the first in his family to have high school and college degrees, stated that he would sing a traditional song to close out this part. (He then did so.) He spoke poetically about spiritual beauty and concluded his remarks by declaring that the Commissioners would remember them when they leave this meeting, because now they see real Native indigenous people.

Chair Poat remarked that we all live in communities that have a variety of needs and what the Commission is trying to do is bring the money where they possibly can. He expressed his hope that they can keep working with them and keep those services coming to their community. He thanked the speakers from the Native American Health Center for coming to the meeting.

10. General Public Comment

Prior to hearing the comments, Chair Poat noted the Agenda items for the November Commission meeting:

- To consider adopting the PEI Statewide Program Guidelines.

- An important financial discussion that will frame, with the most up-to-date financial projections, the funding for the MHSA.

- Election of Commission officers for 2010.

- Consideration of more PEI and INN plans for adoption.

- Adoption of a calendar for 2010.

- The presentation by Commissioner Vega of the Client and Family Leadership Committee (CFLC) on the Public Comment Process (postponed from today).

General Public Comment

- **Ms. Delphine Brody** thanked the speakers from the Native American Health Center. She stated that the California Network for Health Clients strongly supports the recommendations of the CFLC and they look forward to (hopefully) their adoption at the next meeting.

  However, one of the recommendations needs strengthening. Rather than limiting public comment to two minutes, it should be limited to three minutes. Also, the idea about limiting comments when many cards are received should be looked at again; more comments demonstrate increased passion on that issue by the commenters.

- **Ms. Mary Hogden,** mental health services consumer from Alameda County, echoed Ms. Brody's comments. She thanked the Commission and stated that she had benefitted from MHSA funds, which have helped her enormously.

- **Ms. Kathleen Derby**, NAMI-California, stated that they agree with REMHDCO's position indicating that at least three minutes of public comment be allowed. Also, two periods of comment should be available. It is important that a process that is meant to be client and family member driven not intimidate or discourage the participation of the individuals that it intends to serve.

- **Ms. Carol Patterson**, consumer liaison at Berkeley Mental Health, stated that she was concerned that the JPA will create another structure that will not be accessible to consumer involvement. She did not see a lot of diversity in the presenters. She echoed previous speakers that 3 minutes is needed for public commenters. She also stated her frustration that, after being present for the orientation, she found out two and a half hours later that the CFLC recommendation portion of the Agenda -- her main reason for being there -- had been postponed.

- **Ms. Cheryl Maxson** again expressed her concerns about the JPA; that it seems to go up to Redding and no further. This needs to be addressed, as a lot of people live above Redding. She also expressed frustration about the delay of the CFLC recommendation.

- **Ms. Donna Barry** reiterated her concern that public comment should be 3 minutes long and that there should be separate agenda time for major organizations to speak. Also, there was a back-and-forth conversation with CMHDA but not with other speakers. In terms of the JPA, there are concerns that a third party is not accountable to stakeholders.

- **Ms. Linda Picton**, California Network of Mental Health Clients - California, discussed the lack of integrated services. She expressed her appreciation for the Native American Health Center presentation and thought that using that as a model might be a good thing to do.

- **Ms. Lisle Boomer** also commented that there needs to be 3 minutes for public comments and there needs to be a public comment period in the morning, before the majority of the audience leaves. Also, the comment cards should be a color other than yellow, which is a difficult color for many people to differentiate.

- **Mr. Steve Leoni**, consumer advocate, discussed a concept called cultural humility, which concerns the assumption about the "box" that a person should be in. Many people belong in more than one box. Some people self-identify very much in one particular culture; others draw from all over the place. We need to ask people who they are, not tell them.

- **Ms. Yvette McShan**, a consumer and CLCC steering committee member, thanked Dr. Thomas for helping her in her life. She also thanked the California Mental Health Network for investing in her life and educating her about mental health issues. She expressed the desire for more people of her color to be on the Commission if possible.

11. Adjournment

Chair Poat adjourned the meeting at 5:03 p.m.