



**Meeting Minutes
November 18, 2010**

**Sheraton Suites San Diego
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San Diego, CA 92101
1-800-325-3535**

1. Call to Order

Chair Poat called the meeting to order at 9:11 a.m.

2. Roll Call

Commissioners in attendance: Andrew Poat, Chair; Larry Poaster, Vice Chair; Richard Bray, Senator Lou Correa, Patrick Henning, Curtis J. Hill, Howard Kahn, David Pating, Don Pressley, Richard Van Horn, and Eduardo Vega.

Not in attendance: Assembly Member Mary Hayashi and Larry Trujillo.

Eleven members were present and a quorum was established.

3. Welcome to San Diego County

Chair Poat introduced Ms. Theresa Bish, Family Member Advocate and Chair of the San Diego Mental Health Advisory Board. She welcomed the Commission and encouraged clients and family members in the audience to meet the Commissioners, and to think of participating on local and state commissions. She enthusiastically introduced Alfredo Aguirre, the Mental Health Director of San Diego County.

Mr. Aguirre stated that San Diego's Prevention and Early Intervention Plan (PEI) was approved by the State in January 2009, and 100 percent of the services in the plan have been implemented. Its success would not have been possible without the input of stakeholders. In 2008 a series of ten community forums of various topics were held; each yielded programs that have been included in the PEI.

As the result of the extensive community planning process, PEI programs are bringing mental health awareness to all members of the community, through public education initiatives and dialogue. Mental health is truly becoming a part of wellness for individuals and the community. Throughout the stakeholder input process, the need to reduce stigma and discrimination was expressed as a key priority.

In September 2010, San Diego launched "It's Up To Us," an \$8.4 million campaign over four years designed to empower San Diegans to talk about mental illness, recognize symptoms, and seek help. Messages in English and Spanish have appeared all over the region.

Ms. Karen Ventimiglia, Mental Health Services Act (MHSA) Coordinator for the County of San Diego, spoke about the "It's Up To Us" Suicide Prevention and Stigma Reduction Media Campaign. The campaign cites the fact that one in four adults will suffer from a mental illness, and one in five children will experience behavioral or mental health challenges every year.

Ms. Ventimiglia pointed out that talking about mental illness should be as common and as openly done as talking about physical illness. The campaign goals are:

- To raise awareness within the community
- To educate the community about mental health and mental illness
- To provide easy access to local organizations
- To initiate a change in perception and inspire wellness among community members

The model that the campaign uses is based on messages that build on previous messages over time; people get to know individuals who are in the TV ads. The campaign uses a three-pronged approach:

- Social inclusion, which tells people that friends, family and community can make a difference
- Social justice, which highlights an individual's ability and inherent right to live a full life
- Whole self-wellness, which looks at mental health as part of our overall health and well-being

A baseline study was conducted which included 602 randomly-dialed phone interviews representing the mix of San Diego demographics. While nearly all respondents agreed that mental health is as important as physical health, a large number would be reluctant to get help for themselves or to talk about their problems. The interviews also revealed that social distance increases as the interaction becomes more personal.

The Hispanic market has statistically higher rates of self and public stigma, primarily among males. They believe it reflects poorly on the family and are less likely to pursue treatment. Older adults also have a higher rate of self and public stigma with more resistance to getting help.

The research reinforced the need to increase the general public's knowledge, as well as encouraging a more supportive and caring community environment with specific calls to action. The messaging suggestions and the research reinforced the value of a positive strength-based campaign that depicts people with mental illness as responsible, able to recover, and able to live full, productive lives.

The campaign targets the general market, the Hispanic market, older adults, Transition-Age Youth (TAY), and primary care physicians. Notably, 70 percent of the general population will go to a primary care physician and talk about their mental health challenges.

Ms. Ventimiglia showed some of the broadcast media messages to the Commission, including television, cable, and radio. Special consideration was made to reach out to the military population, the Hispanic population, and young adults. She showed photos of media signs on buses and billboards as well, and described the website.

In response to a question from Commissioner Kahn, Ms. Ventimiglia said that San Diego County is in discussion with Shasta County, which would like to have its own media campaign and could share the materials that San Diego County has produced. In response to a question from Commissioner Henning, Mr. Aguirre stated that the materials are available to the California Mental Health Services Authority (CalMHSA) and any California county.

4. Adoption of October 28, 2010 Meeting Minutes

Motion: *Upon motion by Commissioner Kahn, seconded by Vice Chair-elect Van Horn, the Commission voted to adopt the October 28, 2010 Minutes.*

5. Status of PEI Reducing Disparities Statewide Project Strategic Plan

Executive Director Sherri Gauger addressed several questions that had been raised at the September 2010 Commission meeting after having spoken with Department of Mental Health (DMH) Director, Dr. Mayberg.

She had it confirmed that the \$1.5 million per year for strategic planning supports the five individual strategic plans, as well as the MHSA Multi-Cultural Collaborative and a contract for the facilitator who will also write the final Strategic Plan.

The funding was approved by the Administration and the Legislature through the Budget Change Proposal process. Overall about \$3 million will be dedicated for strategic planning. Executive Director Gauger pointed out that the funds were from the five percent MHSA Administrative Fund, not the \$60 million from the PEI Statewide Projects.

The DMH will continue to oversee the development of a Strategic Plan, expected to be completed in June 2012, at which time that Plan will come to the Commission for approval. Staff will be working with the DMH, counties, stakeholders, and partners to identify the funding mechanism for expenditure of the \$60 million.

During the next 12 months, the Mental Health Services Oversight and Accountability Commission (MHSOAC) will be developing the guidelines for the Reducing Disparities project.

6. Adopt 2011 Work Plan Priorities

Chair-elect Poaster introduced a presentation on MHSOAC Work Plan Priorities for the calendar year 2011. He pointed out that the Work Plan becomes the way the Commission conducts business over the next year; it helps inform committee charters and sets up a system of accountability.

Executive Director Gauger and staff developed the Work Plan. Executive Director Gauger walked the Commissioners through it. Highlights are below:

- We are continuing with the same mission as 2010
- Priorities follow:
 1. Continue to implement the accountability framework
 2. Update and align current plans with knowledge learned from evaluations
 3. Address the period of financial volatility 2011 through 2014
 4. Achieve measurable improvement in reducing stigma and discrimination
 5. Envision opportunities for restored financial growth in 2014 through 2019 and assure development of policies that are consistent with MHSA
 6. Review MHSOAC processes
- Executive Director Gauger supplied details of each priority
- She closed with a proposed timeframe

Chair-elect Poaster made two points: first, that the Commission is very short on staff, but will keep our focus and move forward. Second, that he and Vice Chair-elect Van Horn will be meeting with the leadership of each committee. Chair-elect Poaster personally is a proponent of task-focused workgroups that disappear after their task is accomplished. Committee leadership needs to ensure that there is appropriate representation on the tasks that the Commission needs to accomplish.

Chair-elect Poaster named the leadership for the committees:

- Evaluation Committee: Commissioners Van Horn, Pating, and Kahn
- Funding Committee: Commissioners Poat and Hayashi
- Services Committee: Commissioners Pating, Bray, Hill, and Henning
- Client and Family Leadership Committee: Commissioner Vega
- Cultural and Linguistics Competence Committee: Vice Chair-elect Van Horn (Interim)
- Mental Health Planning Council (MHPC); Commissioner Henning will continue as the MHSOAC representative on the MHPC

Chair Poat highlighted Priority 2: Update and Align Current Plans with Knowledge Learned from Evaluations. He stated that this speaks to the continuing evolution of the Commission. At the beginning, we were just trying to get all the programs up and running. Through the good work of a number of the Commissioners, we wanted to get the evaluation process moving; that is now happening, and will be a strong focus for the next two years. This priority is a critical addition to the Work Plan.

Public Comment

- Ms. Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that the Work Plan was a good basis for beginning the year. REMHDCO has enjoyed working with Executive Director Gauger and finds her very accessible. REHMDCO has a slight recommendation under Priority 4: that it go to the Cultural and Linguistic Competence Committee (CLCC) with support from the Services Committee.
- Ms. Delphine Brody, Public Policy and Mental Health Services Director of the California Network of Mental Health Clients (CNMHC), echoed Ms. Hiramoto's concern regarding the Work Plan priority in terms of which committee is assigned which task. She supported the Services Committee being assigned the task of reviewing and approving the statewide program plans, although she hoped that the Client and Family Leadership Committee (CFLC) could do so concurrently on those three strategic plans. When it comes to the assignment of achieving measurable improvement on reducing stigma and discrimination, she would like to see CFLC and CLCC have that charge.
- Ms. Kathleen Derby, MHSA Policy Coordinator for National Alliance on Mental Illness (NAMI) California, acknowledged with Ms. Hiramoto and Ms. Brody the hard work of Executive Director Gauger and the staff. NAMI California recommended amendments to the Work Plan as stated by Ms. Hiramoto and Ms. Brody. Ms. Derby expressed the hope that MHSOAC was able to review the recommendations that a diverse collaboration of community stakeholders had presented in writing. There is a dramatic need to call on the experience of specific groups of stakeholders, particularly regarding Priority 4.
- Dr. Dixie Galapon, Union Of Pan Asian Communities, concurred with the previous speakers regarding Priority 4.
- Ms. Carmen Diaz, parent and former MHSOAC Commissioner, asked why the CFLC and CLCC committees are just involved in Commission processes. Chair-elect Poaster responded that the Commissioners will be talking about committee structure this afternoon. Commissioner Kahn explained that this is

a way of identifying that one of the priorities is an internal process issue to the Commission: taking a look at the committees, as a governance action.

- Ms. Gwen Slattery, a parent, asked Chair-elect Poaster about committee processes – regarding his statement that certain committees could be disbanded when their work is completed; was he referring to the CFLC and the CLCC?

Chair-elect Poaster responded that every committee has a statement about what it does. When committees share an interest, different ways to form workgroups can be considered around particular tasks.

- Ms. Viviana Criado, Executive Director of the California Elder Mental Health and Aging Coalition (CEMHAC), supported REMHDCO and the CNMHC in the request to consider shifting the responsibility of leadership of Reducing Disparities and Stigma & Discrimination to the CFLC and CLCC.
- Mr. Richard Hayes, Professor of Gerontology and ordained minister, shared his experience as a gerontologist. He remarked that he did not approve of MHSOAC's planning process because the Executive Committee was comprised of people with professional credentials, rather than consumers and families.

Chair Poat acknowledged the correspondence of Ms. Amber Burkan on the subject of representation on the committees. He stated that he hoped to see aggressive outreach to bring people newly entering the system into committee work.

The Commissioners then discussed the motion on the table to adopt the 2011 Work Plan.

In reference to the Commission being short-staffed, Commissioner Kahn asked if there were anything on the list that they could not do rather than do halfway. Chair-elect Poaster replied that the answer was yes. The process is such that this sets up the broad work plan in terms of priorities. Each committee would be meeting in January 2011 and establishing its charter within the frame of the broad priorities.

Chair-elect Poaster remarked that peoples' comments have been heard and the process is still fluid. The 2011 Work Plan is not written in stone.

Motion: *Upon motion by Commissioner Bray, seconded by Commissioner Hill, the Commission voted unanimously to adopt the 2011 MHSOAC Work Plan Priorities.*

Chair-elect Poaster stated that he and Vice Chair-elect Van Horn would sit down with the Executive Director and work out how to go about doing this. He informed the Commissioners that he would be coming back in December 2010 with a revised meeting structure. They would aim to reduce the number of

Commission meetings – to meet every other month. Monthly meetings are a tremendous drain on staff and are expensive.

Senator Correa agreed with the idea of going to staff to examine cost-cutting measures. Chair Poat noted that the accepted practice was to meet in Sacramento from January through September (during the time the Legislature is in session).

Chair-elect Poaster raised the idea of teleconferences every other month. Commissioner Henning noted that having meetings after normal business hours would be helpful for those who must be at work during the day.

7. Adopt MHSOAC Policy Paper on Evaluation

Chair-elect Poaster stated that he and Chair Poat had asked staff to develop a policy paper related to how the Commission views its responsibility in terms of evaluation and outcome measures as a way of exercising oversight and accountability. The Evaluation Committee had reviewed the Accountability Framework and was now presenting it to the Commission for final approval.

Ms. Carol Hood, Staff, gave a PowerPoint summary of the contents of the paper. Highlights follow:

- The MHSOAC is broadening its focus from implementation and county plan review to full-scale program evaluation
- Initial priority will be on projects and programs directly supported by MHSA funds
- As MHSA is more fully integrated into the community mental health system, the MHSOAC focus will be expanded to the entire public community mental health system
- The principles are built on the MHSOAC-approved Evaluation Concept Paper of May 2008. A principle was subsequently added for a focus on continuous quality improvement
- Next steps were given for Phase 2, Phase 3, and PEI evaluations. The Framework builds on each progressive phase collaborating with partners and stakeholders through the Evaluation Committee. It is an ongoing effort.
- The Evaluation Committee suggested some changes:
 - The addition of a stakeholder process analysis
 - The clarification that all four age groups are included in the term “across the lifespan”
 - Emphasize outcome of reduction of disparities in addition to the principle of cultural competence

- Focus on continuous quality improvement that could affect policy development and services

Public Comment

- Ms. Stephanie Welch, California Mental Health Directors Association (CMHDA), congratulated the Commission for moving forward and making this shift. CMHDA believes that accountability through evaluation is the primary, most important additional responsibility that the Commission can help CMHDA with in implementing the MHSA.

Ms. Welch stressed that the MHSOAC should urgently look at the appropriateness of the data being collected. It needs to help them get to the analysis and provide the evaluation that answers questions.

Chair Poat commented on whether the role of the various partners – consumers in the planning process, counties in the accountability process, and the Planning Council – could be outlined more clearly.

Commissioner Kahn remarked that some level of evaluation of everyone's role in this is important, from stakeholders to the DMH to the Commission itself. MHSOAC has a dual responsibility: to consumers and potential consumers of the services, and to the taxpayers who are funding the services. All of the players in the process should be evaluated.

Motion: *Upon motion by Commissioner Kahn, seconded by Vice Chair-elect Van Horn, the Commission voted unanimously to adopt the MHSOAC Policy Paper: Accountability through Evaluative Efforts Focusing on Oversight, Accountability and Evaluation, dated November 8, 2010.*

Chair-elect Poaster thanked the staff for their time and efforts to produce the policy paper quickly.

8. Update on MHSOAC Co-Occurring Disorders Report Recommendations

Commissioner Hill introduced speaker Richard Conklin, Chief Mental Health Clinician for the San Diego County Sheriff's Office. Commissioner Hill noted that the second part of the presentation would follow at a later date, when California Superior Court judges who are passionate about the topic will provide judicial input. He also noted that many stakeholders had given their input and feedback on today's report.

Commissioner Pating began the presentation. He gave the Promise from the President's New Freedom Commission on Mental Health, and stated the motion that MHSOAC adopted in November 2008 making co-occurring disorders (COD) competency a core value. He continued with the following highlights.

- Terms from the MHSA tenets such as "whatever it takes," "integrated services," and "flexible funding" were explained

- Global concerns follow:
 - Approximately one half of people with a mental illness or a substance abuse disorder, also have the other condition
 - Individuals with COD are among California's most underserved
 - COD is pervasive and disabling
 - Insufficient support for integrated COD treatment leads to a paucity of programs and skilled providers
- The weaknesses in California's treatment system were illustrated
- Strengths in the system include the following:
 - DMH and the Alcohol & Drug Programs (ADP) have been collaborating in a Co-Occurring Joint Action Council
 - Thirteen counties have COD Best Practices
 - Blended funding may be a part of the Medicaid 1115 Waiver
- There are many effective national models
- Integration of services can be done by supporting the existing COD State Plan, and transformation through the MHSA. The MHSA is a key player in promoting systemic integration.
- The top recommendations included the following:
 - Tracking integration of DMH and ADP services for COD Population
 - Working toward systemic partnerships
- In listening to the next presentation, Commissioner Pating asked the Commissioners to consider three questions:
 1. Which COD or PEI/INN programs are noteworthy?
 2. What is the status of systemic partnerships and collaborations?
 3. What can MHSOAC do to foster systemic integration going forward?

Commissioner Hill took over the presentation by stating that he had been a Deputy Sheriff for over 34 years, and was shortly to retire from his third term as Sheriff of San Benito County. He made the following points:

In 2010-11 there is a tremendously personal and professional shift occurring in the sheriffs as they come into office, to get a handle on COD. They realize that this process is very much relationship-driven.

Orange County has begun a series of seminars sponsored by the State Sheriffs Association, to talk about the status of this population in the county jails and then move into action.

At one of these seminars in Sacramento, Judge Manley and other Superior Court judges simply started to work on mental health issues within their own courts. They had become frustrated with the recidivism of some people who are unable to maneuver within the criminal justice system based on their situation and the underserved nature it creates. The judges created the catalyst to work collectively with MHSOAC, mental health directors, and stakeholders.

The jail in San Benito houses a population, on any given day, of 17-25 percent COD. Psychotropic medications are very cost-prohibitive to the county; the Mental Health Director is limited as to how far he can go with this population. Judges are becoming more and more receptive to working with the COD inmates.

Commissioner Hill emphasized strongly how the MHSOAC is at the tipping point to do some very good work with this underserved population. It is a gigantic step for Chiefs of Police, Sheriffs, Probation Chiefs, and the court system up and down the State. The 58 counties have various types of problems. However, this process that the Commission is embarking on will come from the ground level up.

Relationships in the counties with the mental health directors have taken a quantum leap toward understanding and expanding this process. Integration is pushing past incarceration into supportive housing and parole.

Richard Conklin and Mary Ann O'Connor, a family member, made the following presentation:

Mr. Conklin started by providing a context for what happens when someone comes into the criminal justice system. San Diego County is unique in having two Lanterman-Petris-Short (LPS) Act certified psychiatric hospitals inside the jail system. Eighty-five percent of the population of 5,500 people in San Diego's seven jails are men. There are five social workers, two interns, and eighteen part-time psychiatrists who see approximately 300 patients a week.

When someone is arrested, a nurse in the intake area does a preliminary screening. Once the person comes into the jail there's a series of screenings. A nurse doing a physical screening also screens for mental health and can perform triage. The patient is scheduled to see a psychiatrist, with an appointment in 24 hours or up to four-six weeks in the future.

Within the jail, in addition to the "outpatient" clinics (psychiatric clinics that provide ongoing care) there are a number of important activities. The department looks at training, treatment, and transition. Law enforcement and detention staff, as well as medical staff, are trained in mental illness – how to manage patients and provide the support and treatment they need. Mr. Conklin's staff also convenes pre-release groups: When a psychiatric patient is leaving custody, they meet with that person to provide resources or make appointments with clinics in the community.

One of the partnerships is a referral network that came about as a result of the community services programs in San Diego. One of the lessons learned is the importance of having wraparound programs.

There are also important partnerships with some local agencies. Recovery Innovations of California is a peer-to-peer organization providing wellness recovery support. The jails also work with the National Alliance on Mental Illness (NAMI) to mirror what they do in helping families, while dealing with the complexities and issues of the criminal justice system. The legal system is adversarial-based. Confidentiality and advocacy for the client is paramount, and helping families to make good decisions for the long-run and overall welfare of the patient is not always at the top of the list.

The community has come to better understand the system through the implementation of the MHSA, with the efforts of the State Sheriffs Association and the Bench. The Bench has come to an understanding and awareness of the importance of what outcomes their decisions have on a person in the criminal justice system who has a mental illness.

Ms. O'Connor shared the story of how her family has been impacted in this process. At a young age, her brother Pat was diagnosed as schizophrenic. The illness was manifested through chaotic encounters with family, isolation, inability to be employed, and relationship impairment. He has never been violent. As a nurse, Ms. O'Connor has had the ability to navigate the incredible ramifications of her brother's illness.

As Pat has grown older, he has become less willing to take medications, saying that as he lives outdoors he needs to stay alert. Charges of resisting arrest or disturbing the peace have landed him in jail.

Now in Santa Barbara, Pat is in a better situation. He has been through a crisis intervention program and is on medication. He lives in a home situation. Police, probation officers, and the medical community have an integrated program whereby they can identify those in the community that have mental illnesses. Instead of an arrest, now there's a referral to the psychiatric hospital.

Ms. O'Connor has inserted herself as a family member into the complexity of the jail system, where once you get in you cannot get out. There's a lot of work to be done to help everyone – attorneys, police, jail intake – to recognize and provide alternatives to incarceration for the mentally ill.

Mr. Conklin concluded the presentation with the question about how current practices in San Diego County are impacting state policy. Feedback from the State level is that successes can be demonstrated by integrated programs. Agencies are looking at things regionally, and looking at the immense human and fiscal costs that result from the lack of integration.

Mr. Conklin encouraged the Commission to find some mechanism for posing the question to counties: Have you looked at the judicial task force report and its recommendations?

Commissioner Hill addressed next steps. He recommended putting together a Roundtable to work with the Judicial Council, and not to leave out the juvenile piece of the criminal justice system.

Chair Poat commented that the Medicaid Section 1115 Waiver had been approved by the federal government since the last meeting. This would help in breaking down all the barriers so the appropriate services are provided in the appropriate places, not the jail setting.

He stated that he would like to see letters such as the one of August 19, which walks through the recommendations on COD, influencing the Work Plan for the year ahead.

Commissioner Pating said that as a policy commission, it is hard for MHSOAC to hear the level of problems at a service level. To bring systems together, MHSOAC can build relationships and provide policies. Sheriffs are dialed into the issues, but this is new territory for judges.

Commissioner Pating proposed that after the Commission hears from one or two judges on the judicial perspective, that the staff facilitate a workshop or some sort of relationship so that the Commission can help the judges to get into the county discussions. They could be at the next level of implementation for the plan that they have put out statewide.

Commissioner Hill noted that he is retiring on December 30 from the Commission. His presidency of the State Sheriffs Association also ends at that time. Incoming president Mark Pazin, the Merced County Sheriff, will continue support from sheriffs in developing relationships.

Commissioner Hill commented that the new State Chief Justice takes office in January 2011. The Commission can let her know that it is engaged in the process of integration, and is interested in moving the process out to the 58 counties. MHSOAC wants to continue the working partnership with her and with the report. The report will not simply sit on the shelf.

Commissioner Kahn suggested that although MHSOAC does not have legislative authority, it can attach strings to the money that it continues to give out to the counties to ensure that the process moves forward.

Senator Correa emphasized that as we are looking at a \$30 billion deficit, making every dollar cost-effective will send a powerful message to the counties and the Legislature as well. He also noted that a good possible solution to the COD issue is right in front of us with this report and the Commission holds a lot of the cards to make it happen.

Vice Chair-elect Van Horn remarked that every full-service partnership that has been funded through MHSA should be treating COD; this is the design and where the term “whatever it takes” came from.

Executive Director Gauger stated that it may be a good idea for staff to go back to the newly-adopted 2011 Work Plan and rethink some of the priorities. Another possibility would be for Commissioners Pating and Hill to meet with the Administrative Office of the Courts (AOC) to form a workgroup. Later, staff could carry it forward.

Chair Poat stated that the next step would be a follow-up put together by Commissioner Pating, who added that the Commission would be hearing reports from DMH on integration in drug programs and Older Adult Services.

The Commissioners discussed funding of programs and ideas for more next steps.

Public Comment

- Mr. Jim Gilmer had been working with focus groups on Skid Row with the California Reducing Disparities Project. Comments from consumers were relative to the social determinants that drive CODs. His encouragement to the whole study, planning, and research was to develop more of a health promotion model, and to bring in some statewide organizations, community-based organizations, and cities. Cities in particular would be able to provide some short-term housing, which is a huge problem.
- Ms. Delphine Brody stated that the voice of CNMHC has been muted lately. She was concerned that we should not move forcefully ahead without hearing from the clients and family members, particularly on the issues being proposed around mental health courts and other criminal justice mental health collaborations.
- Ms. Kathleen Derby read the comments of Mark S. Gale, NAMI California’s Second Vice President. He wrote, “NAMI California supports the recommendations detailed in all three reports reviewed today,...” and elaborated on the statement and ideas for the future.
- Ms. Anita Fisher, NAMI, is the mother of a son with COD who cycled in and out of the jail and prison system. He only had a drug problem along with his mental illness diagnosis, yet he ended up in Pelican Bay. He wasn’t violent or involved in gangs. The symptoms of his illness caused him to act out, and the guards were not trained to deal with mental illness. After ten years in the prison system, with his mother advocating for him, he is finally out.
- Mr. Rusty Selix, Executive Director, Mental Health Association of California, expressed the hope that MHSOAC would create a working group including members of the criminal justice community. He stated that the jails are

people-processing centers. More than two million people are processed through California's jails each year and less than ten percent have insurance. Through the Medicaid 1115 Waiver and coverage expansion initiatives, this can be changed automatically when people are processed if that population can be made a priority.

Also, the Commission should play a key role in making sure that the things being requested are part of the federally required inventory of mental health and substance needs, due in 2014. Last, he stated that full-service partnerships will have access to substance abuse funding, as people with disabilities are moved into Medi-Cal managed care.

- Mr. Richard Hayes spoke about family members who suffered from depression, the Helen Winston psychiatric care system in North Carolina, the rehabilitation potential for addictions, and MHSOAC's issue resolution process.

9. Adopt Comments to Proposed Regulations for MHSOAC Prevention and Early Intervention (PEI)

Commissioner Pating, Services Committee Chair, introduced the topic. Highlights of the presentation are below:

- In response both to its oversight/accountability role and its specific responsibility for PEI, the MHSOAC was providing these comments to DMH.
- Two types of recommended comments were included: clarifications and policy changes.
- There were four substantive areas of PEI policy recommendations:
 1. Reporting
 2. The Community Program Planning (CPP) Process
 3. Defining Early Intervention (EI)
 4. Clarifying General PEI Program requirements

Dr. Deborah Lee, Staff Psychologist, gave the specific recommendations and explained them.

Chair Poat called Ms. Stephanie Welch forward to provide real-time discussion and reaction for what the counties think. She stated that the counties appreciate the shift to outcomes reporting. There are important distinctions between outcomes reporting and evaluation, and releasing the exemption for counties with fewer than 100,000 in population is not supported.

The counties disagree with the description of what should be in the five-year sunsetted Evaluation Plan. Counties have already designed that, so to put in

regulation what belongs in a five-year plan that counties have already begun, and that is sunsetted, does not make much sense.

The specific recommendations follow:

- Reporting:
 - Strengthen consistency of regulations with outcomes-focused evaluation
 - Provide option to support timely reporting of any available outcome data and related analysis
- CPP Process:
 - Relieve counties from conducting additional annual PEI CPP unless the county is creating a new PEI program
 - Make PEI CPP requirements consistent with other components
 - It should be consistent with the outcomes-based model for PEI
- Early Intervention:
 - The current definition of early intervention in the draft Regulations is too limiting and precludes brief treatment for individuals with a mental health disorder early in its manifestation or discovery
- General Policy
 - MHSA requires the use of funds for services that are consistent with recommended best practices

Public Comment

- Ms. Delphine Brody began by stating that the CNMHC has not yet had a chance to review thoroughly the PEI Regulations or the proposed comments. She was speaking based on CNMHC policy positions on related issues. They strongly supported the CPP recommended changes. Regarding EI, CNMHC was neutral on the proposed clarification, but suggested a different one.
- Ms. Stephanie Welch read a guiding principle from CMHDA in making comments. She stated that PEI programs should be a locally-driven process, and that some of the highly prescriptive portions of the regulations should be removed. CMHDA will be recommending a moratorium on any regulations moving forward, because it is ready to move to an integrative plan now, and doesn't see how it's administratively efficient or productive to implement regulations that will have to be revised.
- Ms. Stacie Hiramoto thanked the staff for their hard work and stated that REMHDCO approves of the vast majority of the recommendations. It is concerned about PEI – the population you are serving is different. For stakeholders and community planning, it should look different than the CSS.

- More underserved should be served. REHMDCO wants it documented who comes to the CPP to make sure that underserved communities are there.
- Mr. Rusty Selix stated that he is very troubled by this process. Last year the Legislature changed the law to make MHSOAC, not DMH, in charge of the guidelines for PEI. The idea that MHSOAC has to comment on regulations and be at odds with DMH, when it is now in charge of the guidelines, shows that something is out of sync. He stated concerns with the proposed addition of language “early in its emergence” and “early in its identification” because it creates a loophole that destroys the entire premise of PEI.
 - Ms. Kathleen Derby commented that she agreed with Chair Poat on the suggestion that the Commission maintain the status quo in the implementation of a plan. There should still be community discussion and involvement. She also had questions as to how the CPP process is integrated and how this all comes together.
 - Dr. Rocco Cheng, Pacific Clinics and Asian Pacific Planning and Policy Council, stated that in PEI services, many times the models do not include culturally diverse communities, so he appreciated expansion of the definition beyond the traditional Emotionally Disturbed Person (EDP). Also, he supported the continuous solicitation of community input. Last, he supported accountability in PEI programs.
 - Dr. Sergio Aguilar-Gaxiola, Director, University California Davis Center for Reducing Health Disparities, agreed with Mr. Selix and Dr. Cheng. Also, Ms. Hiramoto’s recommendation to require a level of accountability by the counties made a lot of sense. It is difficult to make progress when you are not able to measure things.
 - Ms. Lin Benjamin, California Department of Aging, stated that they supported the proposed recommendations and revisions; however, they disagreed with restrictive language in PEI funding distribution, because older adults have late onset of major depression, which is the strongest risk factor for suicide in that age group.
 - Mr. Jim Gilmer said that speaking as a PEI Plan evaluator, he was very concerned about how county plans are actually implemented and measured, particularly around reducing racial and ethnic disparities. He was also concerned about the congruency of what is in the plan and how it is actually implemented. He supported the MHSOAC staff’s recommendations.

Commissioner Pating commented on the feedback he had heard regarding the four recommendations.

1. Reporting: the general consensus supported going to a three-year report of PEI outcomes, and doing a more substantive report was better than annual updates. The contention was whether to exempt the smaller counties.
2. CPP: In the recommendation to eliminate the entire section 3900, the Services Committee's strategy was to translate the guidelines into regulations. The instruction to the staff was not to rewrite the guidelines. The Committee's recommendations reflect clarification and some policy fixes to simplify the process further and it was not to change the guidelines including the 51 percent.
3. EI: After hearing Mr. Selix's comments, Commissioner Pating was concerned about slipping into a legal loophole but does not want to delay submitting these comments. There will be opportunity in the future during the 15-day review to make further recommendations to close the legal loophole. The Committee was trying to address another problem that came out of the guidelines: what group of people is EI addressing?
4. There was no disagreement on the definition of best practices.

Vice Chair-elect Van Horn commented that the MHSOAC put in the figure of 51 percent as a compromise which brought down the figure from 75 percent. Commissioner Van Horn pointed out that 75 percent of all mental illness is determined by age 25 and the child advocates on the Commission were pushing for 75 percent of all PEI money to be used for up to age 25.

Commissioner Vega supported the perspective that with these resources we need to massively change the impact of mental illness across generations. He did not think that it is necessarily the case that we have to state that other resources could not be differentially dedicated. He asked the question: Under the current regulations, beyond the 51 percent, is there a reason a county cannot determine to use 49 percent for older adults, for example?

Dr. Lee replied that except for small counties, the needs of all age groups must be addressed. That is the second current requirement.

Commissioner Pating proposed that the Commission vote on each of the general recommendations.

Dr. Lee then went through the six recommendations with which the Commissioners could agree or disagree.

1. To have the one local outcomes evaluation for PEI programs to sunset and to give counties five years flexibly to report on all PEI programs. The Commissioners unanimously agreed.
2. CPP with the existing regulations is sufficient to ensure that it happens annually with regard to the status of existing programs. The complete,

3. documented CPP can be reported on every three years. The Commissioners unanimously agreed.
4. To remove the language in the draft regulations that a county can submit a corrective action plan instead of documenting that the required participation was met. The Commissioners unanimously agreed.
5. To restore the language currently in the guidelines to the draft regulations that documenting the CPP (every three years or for a new program) would note the data and community input that led to the decision about community priorities. The Commissioners unanimously agreed.
6. Part A: It is all right to include people with a diagnosis in Early Intervention. The Commissioners unanimously agreed.

Part B: To allow people to qualify for Early Intervention based not just on early onset but also on early identification. The Commissioners disagreed with the recommendation because the risk of creating a loophole outweighs the benefit of opening potential access. Commissioner Pating noted that they could clear it up later on when get to integrated plans.
7. To take the language in the guidelines about best practices defined flexibly as deriving from both research and community practice, and making that a requirement for a funded PEI activity. The Commissioners unanimously agreed.

10. Honor Outgoing Commissioner Curtis Hill

Chair Poat stated that Commissioner Hill, after joining the MHSOAC one and a half years ago, had done a phenomenal job not only representing the law enforcement community but also bringing others into that conversation, acting as an ambassador, and helping the Commission to understand all the issues the law enforcement community has to deal with.

Besides being a Sheriff, Commissioner Hill had been an active member of the Commission. Chair Poat expressed appreciation for his committee work and special assignments that he'd been willing to take on. Chair Poat shared with Commissioner Hill a joint resolution from the Legislature, and thanked him for his Commission work.

Commissioner Hill stated that it was an honor to be on the Commission. There were two things he would continue to have a passion for: the mentally ill and organ donation. It was an honor to serve alongside the other Commissioners.

11. PEI and INN Plan Approval/Status Update

Dr. Lee presented two plans.

- INN Plan Approval/Status Update

- Kings County has withdrawn its plan because the county changed it and will be resubmitting it within 30 days
- PEI Plan Approval/Status Update

Dr. Lee noted that Del Norte County is the last of the 58 counties, plus the City of Berkeley and the Tri-Cities for the Commission to approve.

- Del Norte County submitted an exemplary community plan, working with various ethnic groups (Southeast Asians, Latinos, and Native Americans) to provide very specific outreach and engagement. The County also tied education on PEI to social issues in the county. The two projects are culturally sensitive and flexible.

Recommend approval of \$415,800.

Commissioner Vega recognized the staff work of Dr. Lee and the other staff in getting the Commission through this process of reviewing PEI plans.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Hill, the Commission voted unanimously to approve the Del Norte County PEI Plan.*

12. PEI Celebration

Commissioner Pating declared victory for Chair Poat's effort to get out the money to the counties. The Commission has now established \$713 million in prevention monies going out to the State of California, the largest amount of any state in the country.

Commissioner Pating recognized Ms. Ann Collentine, Mr. Clark Marshall, Ms. Enrica Bertoldo, and Dr. Deborah Lee, as well as the counties, participants, and stakeholders in all the different meetings. The plans show California's creativity at its best.

13. Adopt Comments to Proposed Regulations for MHSA Capital Facilities Outlay

Commissioner Pating announced that Dr. Lee would present proposed changes to the MHSA Capital Facilities Outlay regulations. She explained the two recommendations:

1. The addition of a prevailing wages requirement to the list of federal and state laws that are referenced in the draft regulations
2. To seek clarification language in the initial Statement of Reason (a foundational document for the draft regulations) to allow an exemption from rent for vocational services when the vocational services are part of the mental health service being provided

Ms. Dee Lemonds, Staff, took questions from the Commissioners.

Chair Poat inquired about building requirements and the application of the Davis Bacon Act regarding wages. Dr. Lee responded that in the draft regulations there is a list of various federal and state laws that would be applied; the suggestion is to add prevailing wages to that list.

Vice Chair-elect Van Horn noted that a huge number of projects have been done around the State without prevailing wage requirements. Chair Poat felt that this was not in the Commission's purview to decide – it would be for the voters or the Legislature to decide what laws govern the expenditure of state dollars.

Ms. Lemonds remarked that this was the same recommendation that the Commission made on the General System Development Housing regulations. Ms. Filomena Yeroshek, staff Legal Counsel, clarified the recommendation by reading directly from the recommendation to show that the prevailing wage requirement was not being added as a requirement but it was merely being added to a laundry list of laws and regulations that might be applied if applicable.

Public Comment

Ms. Stephanie Welch brought forward an important policy issue for CMHDA: public funds. Exclusionary language in the regulations says that in order to use capital facilities funds on anything except renovations, you must be a county-owned entity. But counties don't necessarily own these buildings. As long as the intended purposes for the structure are for public good, and there are several different layers of accountability that CMHDA feels are in place at the local level that also can be provided to the State, services and benefits to the public can continue to be provided in these facilities.

Ms. Delphine Brody commented that CNMHC strongly agrees. For counties to receive any sort of public facilities funding for mental health programs, it is extremely important that the county not be required to own the property. This would also open the door to peer-run, family-run, and community-run programs for those who are unserved and underserved.

Commissioner Pating noted that the Services Committee did not review the draft regulations on capital facilities. Ms. Lemonds commented that neither the committee nor staff had been part of the discussion that Ms. Welch presented and had not seen the full analysis.

Vice Chair-elect Van Horn stated that he agreed with Ms. Welch; Chair Poat and Chair-elect Poaster felt the same.

Chair Poat entertained a motion for the Executive Director to add a third consideration related to the concern that regulations not require county ownership of the facilities in which services are delivered.

Motion: *Upon motion by Chair-elect Poaster, seconded by Vice Chair-elect Van Horn, the Commission voted unanimously to adopt the draft letter providing MHSOAC public comments on the proposed regulations to be sent to DMH and to add the Commission's concern with the sections that require the property to be county owned.*

14. Cultural and Linguistic Competence Training

Vice Chair-elect Van Horn introduced Ms. Doretha Williams-Flournoy, Deputy Director of California Institute for Mental Health (CiMH) and Director for the Center for Multi-Cultural Development. She began the presentation, which examined the ways in which policies implicitly and explicitly influence disparities. Highlights are as follows:

- Excerpts from the film, *Race: The Power of an Illusion*, were shown. Ms. Williams-Flournoy prefaced by noting that people react differently to challenges to long and deeply-held assumptions.
- In the same way that policies were used to create disparities in mental illness, policies can be created today to reduce them or even eliminate them.

Dr. David Grant, Director of the California Health Interview Survey (CHIS), University of California Los Angeles, Center for Health Policy Research, shared current research focused on social determinants that influence mental health disparities in California.

- CHIS has been conducted every other year since 2001. Its data is widely used by state agencies, county health departments, academics, and advocacy groups.
- The data sample is large: 50,000 random telephone calls allocated across all of California's 58 counties. Interviews are conducted in English, Spanish, Chinese, Korean, and Vietnamese.
- The survey content includes the following:
 - Demographic data
 - Health behaviors
 - Health conditions, including mental health
 - Access to, and utilization of, healthcare services
 - Health insurance coverage
 - Uninsured
 - Many other topics
- CHIS has been working with DMH since 2005.

- CHIS data and findings are accessible at www.chis.ucla.edu.
- The survey provides a robust estimate of the percentage of the population with Severe Psychological Distress (SPD).
- There is a strong relationship between poverty level and SPD.
- American Indians/Alaskan Natives have about twice the rate of SPD as the other races/ethnicities, while Asians have considerably less.
- Latino immigrants with adjusted income and education have the lowest rate of SPD of any group.
- Gay/lesbian/bisexual persons experience a high level of SPD: one in five over a 12-month period.
- Single parents experience a high level of SPD: 18 percent over a 12-month period.
- Most adults with need never get mental health service.
- CHIS mental health findings:
 - Findings are preliminary and need further analysis
 - Mental health status differs by age, gender, income, and race/ethnicity and nativity, but SPD is largely a function of economic position
 - Many social differences in mental health status and utilization of treatment are real
 - Most adults “in need” (SPD or perceived) do not get treatment
 - Improving mental health in California’s diverse population will require diverse approaches
 - MHSA and healthcare reform provide new opportunities to address and improve mental health services and outcomes
 - Data and evidence can and should be part of the decision-making process

Dr. Aguilar-Gaxiola, Director, University California Davis Center for Reducing Health Disparities, pointed out that childhood adversities are strong predictors of the early onset of mental disorders, as well as chronic health conditions. This has tremendous implications for prevention.

Dr. Aguilar-Gaxiola also noted that in particular, being an immigrant appears to be related to factors that protect mental health. We need to learn from those associated factors.

15. Adopt Committee Structure for 2011

Chair-elect Poaster explained the two options proposed at the October 2010 meeting for the Commission committee structure:

1. Status quo: maintain the existing five committees with a new membership
2. Eliminated two committees and formed an additional committee. This would help the Commission achieve one of its major goals: the development of a mechanism and a way of reporting back through the use of community forums or policy meetings. Equally important, the development of ways to take the information gathered and bring it back to the Commission.

No resolution was reached last month and the Commissioners requested that this issue be on this month's agenda.

There was a lot of input and ideas received last month at the Commission meeting and at the various committee meetings between last month's meeting and this month's meeting. Inspired by a conversation with Commissioner Vega, a third option was developed: to maintain all five committees, but requests the CLCC and the CFLC take responsibility together to develop community forums and to figure out how to report the information back to the Commission. Under this option, the Chairs of these two committees would work out the process. Idea would be that the committees would meet on the same day in the morning and in the afternoon portions of the committees would meet to plan the forums. Because this option does not change the committee structure as set forth in the Rules of Procedure there is not need for a vote.

The Commission has received an additional proposal from the community stakeholders.

Executive Director Gauger went through a PowerPoint presentation and stated that as a result of the significant discussion last month, the Commissioners asked staff to identify a simplified framework of activities that could be a part of charters for the CFLC, CLCC and a potential new Community Outreach Committee (COC). She presented the potential framework of activities. A potential activity for all three committees would be to review MHSOAC processes and make recommendations regarding the perspective and participation of those with severe mental illness and their family members.

After listening to stakeholders input and the Commissioners' goals staff developed a proposed new Option 3: Maintain the current five committees. In addition to the individual CFLC and CLCC meetings, four to eight members from the CFLC and CLCC would come together to form a Community Stakeholder Task Force would be charged with the responsibility of convening the community forums and reporting back to the Commission. Suggest the CFLC and CLCC coordinate their meeting dates to meet in the morning as separate committees and in the afternoon come together to plan the community forums.

In addition, Option 3 includes ideas important to all the committees as set forth in the PowerPoint.

Chair-elect Poaster repeated that Option 3 does not require any substantive changes and there is no need for the Commission to take action.

Public Comment

- Ms. Crystal Crawford, California Black Women's Health Project, stated that Option 3 seemed reasonable to her organization.
- Ms. Brody said that Option 4 represented the recommendations of four community stakeholders groups and four government agencies. Option 3 was the most amenable of the first three. In response to a question from Commissioner Vega, Ms. Brody stated that they were neutral on the formation of the community forums.
- Ms. Derby commented that Ms. Brody's recommendations would be valuable, considering the expertise factor in populating the committees would be important, because it would result in having many clients, family members, and members of unserved and underserved communities. She also noted that NAMI California would support the formation of the Community Outreach Committee by members of the CFLC and CLCC.
- Ms. Aleyda Toruno, Disability Rights California, stated that her organization was happy with the decision to keep the committees intact.
- Ms. Viviana Criado, California Elder Mental Health and Aging Coalition, thanked the Commission for its effort to listen to the community and to move in this direction. She encouraged Commissioners to have every committee include the views of youth and older adults.
- Ms. Benjamin thanked Ms. Gauger for working with the stakeholders. She also emphasized the importance of having all committees look for opportunities to include the perspective of all age groups.
- Dr. Cheng stated that his organization supported Option 3, and Option 4 was actually more specific. Regarding the community forum, he really liked the idea. Having it would enable more input from the community, useful in implementing policy.
- Ms. Hiramoto stated her agreement with the previous speakers.

Chair Poat remarked that the Commission had now established guidelines for committee membership that reflect each of the populations laid out in the MHSA. He asked whether the Commission had slots for Transition Age Youth (TAY) and senior citizens. Executive Director Gauger replied that it was not in the Rules of Procedure. Commissioners Vega and Pating responded that the CFLC and Services Committee did have slots.

Commissioner Pating supported the idea of client, family, and ethnically diverse participation on all committees. At the same time, he felt that in setting up separate committees, an eventual integrated, broad, and inclusive system that treats all unserved, underserved, and inappropriately served would be more difficult to achieve. While the Commission is splitting these issues up, at the same time it is working toward a common understanding.

Vice Chair-elect Van Horn stated that as the Commission sets up cross-committee work groups around specific tasks, it needs to make sure that those work groups reflect the cluster that needs to focus on the task.

Chair Poat concluded that the Commission had seen some very good work, led by the incoming Chair, the Executive Director, and many interest groups. There was a good consensus going. The Commission would stick with the committee structure it has and there was no need to vote at present. Many good ideas had come forth and they could be integrated into an interesting process.

16. General Public Comment

- Ms. Elisa Hickman, a parent, stated that she and other adults would like to see more resource centers in the community, more representatives to inform communities on what resources are available, and more programs for Early Intervention issues for parents.
- Ms. Diaz commented that many acronyms were used today, and the public does not always understand them. She thanked Commissioners Vega and Van Horn for remembering the fight with the 51 percent. She suggested that when evaluations are done, that they are given to people who are actually receiving the services.
- Ms. Brody thanked the CLCC and today's presenters. She was struck by the emerging data showing the correlation between socioeconomic class and sexual orientation, with SPD. She asked that the Commission keep the importance of lived experience of trauma in childhood at the forefront of its thinking for 2011. She also thanked Commissioner Vega and the CFLC for making the difficult decision to cancel tomorrow's community forum.
- Mr. Jorge Cabrera, Board Member with Survivors of Torture International, commented that his organization has presented its work to the Commission before, and now was taking this occasion to report back. *Survivors* provides treatment services to those who have endured torture in their home countries. For nearly three years, *Survivors* has contracted with San Diego County for part of its services using MHSA funds. The contract is vital. Mr. Cabrera had provided a packet for the Commissioners to review. San Diego County is the leading humanitarian immigrant resettlement destination in the United States. *Survivors* looks forward to continuing to partner with the county in the years to come.

- Ms. Maria Salinas, a parent, expressed her concern regarding the funding being deducted to all of indigenous families that have worked very hard. She and her family need certain types of services. She hoped that the Commission would ensure that funds are available to all families that are in need at this moment.
- Ms. Flor Erickson requested more minority groups to be represented in the Commission. They feel that not all are represented. Also, she strongly recommended giving parents time to comment to the Commission. They are the ones who face the challenges with their kids, and need Latino services.

17. Adjournment

Chair Poat expressed satisfaction that all of the PEI programs are now adopted. This is an important message to get out to voters and taxpayers; the PEI program is important and it's working.

Chair Poat adjourned the meeting at 5:51 p.m.