

MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
September 22, 2011

California Institute for Mental Health
Sequoia Room
2125 19th Street, 2nd Floor
Sacramento, California
866-817-6550; Code 3190377

1. Call to Order

Chair Poaster called the meeting to order at 9:11 a.m. He thanked everyone in attendance for coming.

2. Roll Call

Commissioners in attendance: Dr. Larry Poaster, Chair; Richard Van Horn, Vice Chair; Sheriff William Brown, Dr. Ralph Nelson, Jr., Andrew Poat, Eduardo Vega, and Tina Wooton. Senator Lou Correa joined the meeting after the roll call.

Not in attendance: Dr. Victor Carrion, Assemblymember Mary Hayashi, Patrick Henning, Jr., and Dr. David Pating.

Eight members were present and a quorum was established.

Chair Poaster relayed Commissioner Carrion's regrets that he would be unable to attend both today's Commission Meeting and the November Commission Meeting. Commissioner Carrion wanted Chair Poaster to assure everyone that he fully intends to attend and participate in the January Commission Meeting. Chair Poaster also noted that Commissioner Pating would be absent from today's meeting due to the nursing strike at the Northern California Kaiser facilities.

3. Adoption of July 28, 2011 MHSOAC Meeting Minutes

Commissioner Vega noted that the California Mental Health Services Authority Update should be referred to as semiannual rather than biannual. He also directed staff to verify the affiliations listed for Ms. Catherine Bond.

Motion: *Upon motion by Commissioner Poat, seconded by Commissioner Nelson, the Mental Health Services Oversight and Accountability Commission (MHSOAC) voted unanimously to adopt the minutes of the July 28, 2011 MHSOAC Meeting as corrected.*

4. MHSOAC Revised Calendar, September 2011

Chair Poaster noted that the MHSOAC Calendar has been revised for the remainder of the year.

Chair Poaster directed Executive Director Sherri Gauger to check with the Commissioners and ascertain whether the Commission meeting scheduled for November 17, 2011 should be rescheduled.

5. MHSOAC Dashboard, August and September 2011

Chair Poaster stated that the MHSOAC Dashboard has been revised for the remainder of the year.

Commissioner Poat inquired as to whether the development of regulations is proceeding. Executive Director Gauger responded that the Department of Mental Health (DMH) is going to convene a meeting on September 29th, 2011 that will include the California Mental Health Directors Association (CMHDA), the MHSOAC, and others to begin the process of reviewing all the current MHSA regulations and determining if they need to be amended or repealed in light of Assembly Bill (AB) 100.

Executive Director Gauger noted that the November 17 Commission meeting would be held in a new location. Staff prepared a flyer notifying the public of the new location and it is a handout to today's meeting packet.

6. Services Committee

Presentation: Prevention and Early Intervention 2011 Trends Report

Dr. Deborah Lee, MHSOAC Consulting Psychologist, presented the updated 2010 Prevention and Early Intervention (PEI) trends report. This report looks at all counties' initial approved PEI plans. Below is a summary.

- PEI is not only a Mental Health Services Act (MHSA) priority, it is also a national and worldwide priority.
- A PEI goal that the MHSA lists is to try to prevent negative and costly consequences of serious mental illness, by linking the mental health aspect to the larger social context.
- This report is based on what counties said they were going to do, rather than actual on-the-ground assessment. Having the descriptions of county plans shows their richness and creativity.
- Most of the negative outcomes emphasized in the PEI Guidelines (school failure or dropout, preventing incarcerations, suicides, etc.) were embraced by 75 percent of the counties.
- Eighty-six percent of the counties had programs that addressed co-occurring disorders.
- In the PEI Guidelines, prevention programs are expected to focus on individuals *prior* to diagnosis of a mental illness. This was a policy the Commission came up with several years ago to try to jump-start prevention in California.

- Ninety-seven percent of counties have at least one prevention program, while 97 percent of counties also have at least one early intervention program.
- Except for small counties, PEI programs must serve all age groups and a minimum of 51 percent of funding goes to children and youth. 97 percent of counties have programs for children, 95 percent for transition-age youth, 93 percent for adults, and 80 percent for older adults.
- A large number of counties had programs that focused significantly on a particular racial or ethnic group.
- Fifty-one percent of counties offered a PEI program that included a focus on lesbian, gay, bisexual, or transgender (LGBT) individuals.
- Family involvement and peer support are strongly endorsed.
- One of the strongest parts of the PEI Guidelines is that it is based on a logic model that is founded on outcomes.
- There was not a requirement to measure outcomes.
- California Institute for Mental Health (CiMH) has almost completed an e-learning curriculum for innovation evaluation that has broad applicability to PEI.
- A key priority is to develop an evaluation framework.
- MHSOAC has talked about working with the California Mental Health Planning Council to define priority indicators for PEI. So far the focus has been on Community Services and Support.
- There are aspects of the PEI Guidelines, such as the focus on outcomes from the beginning and the focus on links to other systems, that could be applied to other components when we get to a more integrated approach.
- Providing support to counties, especially small counties, to be able to do evaluation is important in terms of technical assistance.
- It is also important that clients in PEI programs be involved in planning.

Questions and Discussion

Commissioner Poat stated that reports like this could be used to inform the conclusions in the annual report the Commission will be submitting to the Legislature. He also indicated that the presentation would benefit from a slide explaining what we learned from this review for purposes of future data collection. He would like the actions and activities for the MHSOAC listed in addition to actions and activities that will be handed off to others. Dr. Lee responded that she had the recommendations and she would be happy to incorporate them into the presentation and make them available to the Commissioners. Commissioner Poat felt that next step recommendations are very important to the Commission's work and should be included in future presentations.

Commissioner Brown referred to the absence of requirement for the counties to measure their outcomes. He asked how many counties are measuring their outcomes, and if the evaluation done by this body through Dr. Lee meets the standards of establishing whether or not particular programs are evidence-based practices.

Dr. Lee responded with four points:

1. Counties (except small ones) are required to do evaluation of one PEI program where they measure outcomes. As part of the MHSOAC evaluation, the University of California, Los Angeles (UCLA) is doing a summary and synthesis of what is available right now. This will be ready for the next MHSOAC meeting.
2. Some counties, including five small ones, are collecting data on other outcomes beyond local evaluations. It is preliminary at this point and there is not a lot of data from which to draw conclusions yet.
3. With regard to the Trends Report before the Commission today, it is a compilation of what counties intended to do, not an evaluation.
4. With regard to evidence-based practices, the PEI Guidelines have requirements that counties must use some level of evidence to support the programs that they are proposing. It doesn't have to be evidence-based practice; it could be a range of evidence.

Commissioner Brown noted that this was encouraging on a couple of levels. Particularly with the smaller counties, if there were a requirement for that component, their limited funds would have to be spent on evaluation rather than delivery of service. At the same time, counties are given the latitude to try unique programs for their environments.

Commissioner Vega would like to see a map of evaluation efforts to help the Commissioners remember which agencies and organizations are responsible for the different pieces of evaluation. He also asked Dr. Lee how we integrate the various evaluation efforts. Dr. Lee responded that we are in the preliminary phase of evaluation. The California Mental Health Planning Council will be leading the public input process for the approval of priority indicators relevant to PEI outcomes.

Vice-Chair Van Horn commented that there are not a lot of evidence-based practices yet in the PEI arena. He also pointed out that the reason co-occurring disorders were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition. It is clear that co-occurring disorders need to be dealt with at the same level. Dr. Lee added that realignment is working in the sense of local prioritizing. There are not a lot of evaluations going on currently, except what is happening at the county level and what the California Mental Health Services Authority (CalMHSA) is doing for their statewide PEI evaluation and efforts.

Commissioner Vega pointed out that results from some PEI programs, particularly those involving youth, cannot be known until years later. The Commission should think about ways to show long range impacts in addition to the short term impacts that current evaluation efforts are focused on.

Commissioner Poat agreed, and suggested coming up with a graph or visual for the report to the State Legislature, indicating who is leading accountability and what the initiatives are with respect to each of the program areas.

7. CMHDA Presentation on County-Specific Outcomes Data

Ms. Pat Ryan, CMHDA Executive Director, introduced the presentation by noting the importance of recognizing good outcomes happening at the local level.

Mr. Mark Refowitz, Deputy Agency Director at Orange County Behavioral Health Services (BHS), began by talking about the beginning of the county's outcome system. Three steps led to success:

1. From the beginning of the MHSA, the county worked with the Mental Health Association of Los Angeles.
2. The outcome system was based on how they could make a difference in peoples' lives. They used the Milestones and Recovery Scale (MORS) in terms of measuring people's progress.
3. They also made sure, in each Full Service Partnership (FSP), that they had a staff position for a data analyst, who collected data and brought it back. On a regular basis the agency could meet and talk about what they were finding in the programs.

Mr. Anthony Delgado, Program Manager at Orange County BHS, presented the following:

- The MORS was developed through the MHA Village of Los Angeles. Orange County BHS was looking for a way of following some of the guidance from CiMH and the State in regard to developing systems that allowed for people to come in at their level of need, rather than having “one size fits all.”
- Mr. Delgado listed the Orange County FSPs and their enrollment numbers.
- Mr. Delgado described the Adult and Older Adult Performance Outcomes Department, as well as the work of the FSP data analysts.
- The process of data analysis is to collect it, correct it, analyze it, and learn from it.
- “Annualizing” data is a standardized method that enables Orange County BHS to compare each member’s pre and post enrollment while taking into account that each member has been enrolled for varied amounts of time.
- Mr. Delgado gave figures for reductions in hospitalized days (67.6 percent), reductions in incarcerated days (87.9 percent), and reductions in homeless days (63.7 percent).
- He gave figures for increases in employment days (4.2 percent) and increases in members in education (54.9 percent).
- A software program called Tableau allows data extraction from the database and querying in many kinds of ways.
- A graph showed Telecare discharges from Fiscal Year (FY) 2007 to FY 2011.
- The Employment Aspiration Survey is a satisfaction survey developed by Orange County that was published in the International Journal of Psychosocial Rehabilitation.
- Current efforts are management meetings focused on data, and markers for FY 2011/12 on graduation rates and individualized intervention strategies.
- Mr. Delgado listed projects that have been undertaken based on the data. Orange County BHS is waiting to hear whether the projects have resulted in improvement in outcomes.

Questions and Discussion

In response to a question by Commissioner Nelson, Mr. Delgado stated that graduation from an FSP is a collaborative process. The member must feel ready and the program staff looks at what a member will need to sustain him or herself in the community over time. Anyone who graduates from an FSP and needs to come back is given priority in returning to the program. They always return back to the FSP of origin because of the connections and support that a member has there. When a member graduates from an FSP, they are connected with a provider in the community. This is set up two to three months prior to graduation. A member might go into a step down program, where fewer services are provided but they are still monitored.

Commissioner Poat wanted to know how many people in Orange County would be served by the FSPs if there were no fiscal limitations on enrollment. Mr. Delgado said it was a difficult question to answer as the nature of the FSP is to treat clients and then transition them back into their communities. It is not intended to be a standing treatment modality.

Commissioner Poat, Mr. Delgado, and Mr. Refowitz agreed that employment is a challenging need to meet in the whole recovery process. The hiring freeze in Orange County and the overall downturn in the economy have made it harder to find employment for FSP graduates. Commissioner Poat voiced the hope that the Commission would take more time on the subject of employment.

Commissioner Wooton was appreciative that although the employment data looks low, at least data is being collected. She was also appreciative that Orange County did the "Measurement of Vocational and Educational Aspiration and Satisfaction among Mental Health Clients" survey and made it available on:

http://www.psychosocial.com/IJPR_15/Vocational_Measurement_Rich.html

Vice-Chair Van Horn pointed out that the MHSOAC will need to take a serious look at the issue of employment after realignment.

Senator Correa, addressing the tragedy of the death of Kelly Thomas, asked about officer training in Orange County on the issue of mental health. Mr. Refowitz responded that since the tragedy in July, numerous police departments have been calling to request additional training. Orange County BHS will probably double or triple the number of available classes for police in the county. The agency has trained just under 1,000 officers under the Crisis Intervention Team (CIT) model, based on the "Memphis Model." Senator Correa stated that this tragedy serves to underline the need to increase our efforts in this area and to continue the training and understanding of the first responders. He will be looking at this area from a legislative policy perspective.

Commissioner Vega stated that San Francisco has been working to implement a new CIT Program that is built on a new model. While the CIT model is good, he felt that it does not adequately address some of the underlying issues of bias, discrimination, and officer fears. Training officers in the CIT model does not necessarily solve systematic social problems. His hope was that we would take advantage of this opportunity to zero in on the stigma issues in our communities.

Senator Correa commented on the other issues highlighted by this tragedy, especially stigma. The victim was known to be a person with mental health issues by those in the area, yet someone still felt compelled to call the police. Were the victim's previous incidents recorded in a database that first responders had access to or does a first responder start from scratch every time they go to a situation?

Public Comment

- Ms. Kathleen Derby, National Alliance on Mental Illness (NAMI) California, commented that Orange County BHS possibly had the commitment to collect data before they had the resources. The peer mentorship that they decided to do is very important and maybe we should be encouraging other counties to do this and to learn from each other. An increase in education is the pathway to employment. She appreciated that they looked at data beyond the DCR data and that they emphasized the aspiration survey. In the future, she would like to hear about outcomes for clients and family members who are not in the FSPs because the vast majority of NAMI California's clients and family members can not be served by FSPs.
- Ms. Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), reminded the Commissioners that it appears from anecdotal evidence that FSPs are not serving people from ethnic and racial communities in the way or proportion that they should. However, FSPs could be a model that works for people from communities of color. She commended Orange County for their PEI programs, which were designed to reach racial and ethnic underserved communities as well as the communities at large. One of the PEI programs had the word "promotores" in it and because of that, the funding was initially delayed. In serving people from racial and ethnic communities, it is important to remember things like this still go on.

- Ms. Linda Hart, African American Mental Health Coalition, wondered if the Orange County BHS had data on how many of the 740 enrolled in the program were of African American descent. Ethnic data is important to include in outcomes. Mr. Delgado responded that two percent were of African American descent and one percent of the population of Orange County is African American. This data is on the Orange County BHS website. Ms. Hart stated that San Bernardino County was successful in having the promotores funded. She expressed that it would be nice to see consistency across the counties to avoid sending out mixed messages. Consistency is key. It would be good if the Commission could take a look and help guide the counties to be on the same page.
- Ms. Delphine Brody, MHSA and Public Policy Director of the California Network of Mental Health Clients (CNMHC), said that FSPs in general should be made available to unserved, underserved, and inappropriately served populations. Assembly Bill 1421 (Laura's Law) has been the subject of some debate and discussion in Orange County. Regarding the death of Kelly Thomas, the public response needed is not a push for an extension of court-ordered treatment, but for police accountability and civil rights for homeless people with mental health challenges. CNMHC supports Commissioner Vega's recommendation of building on the CIT model and bringing in more peer-lead presentations on social inclusion and the civil rights of homeless people labeled with mental health issues.
- Deacon Donald M. Clark, Seventh Day Adventist Church, commented that there are cascading developments in the Substance Abuse and Mental Health Services Administration (SAMHSA). We all need to become aware of one blatant fact: we have systems that are broken. Twenty-five years ago Deacon Clark was in an Oakland program funded by the DMH and the Center for Mental Health Services. At that time, data on ethnic minorities who were homeless and suffering from a mental health issue was being kept in Oakland and in Los Angeles. We have to find out what went wrong in a quarter of a century. One thing that did not go wrong was that staff received their salaries. Homelessness was not abated. His recommendation was that some of that data should be unearthed now, and examined for how to expand and improve cultural competency.

8. Evaluation Committee

MHSOAC Staff Introduction of UCLA Deliverable 1A

Vice Chair Van Horn introduced Ms. Enrica Bertoldo, MHSOAC Staff, who gave context and background for the specific deliverable the Commission had asked the evaluator to do.

This presentation is a summary of MHSA expenditures and activities known as “Deliverable 1A.” It provided the first statewide summary of expenditures across components for three fiscal years. The report focused on county expenditures at the local level.

Presentation – “Summary of Proposition 63 Expenditures through Fiscal Year 2008 – 2009”

Dr. Elizabeth Harris of Evaluation, Management, Training (EMT) Associates, working in conjunction with UCLA, provided an overview of the report as summarized below.

- Interim objectives included generating baseline information about statewide MHSA expenditures and component allocations, and building a cross-county Revenue and Expenditure database for the purpose of statewide and regional analyses.
- Dr. Harris supplied caveats to keep in mind when reviewing findings, regarding limitations and timing. The findings are as of Fiscal Year 2008/09.
- System-wide findings were that the MHSA is increasingly shouldering a larger share of the cost of mental health services in the public mental health system, as funding from the State (General Fund and Realignment) shrinks.
- Cross-component findings were:
 - Expenditures to support a system of care through Community Services and Supports (CSS) comprises 98 cents out of every MHSA dollar.
 - Population is a contextual factor related to component expenditures.
 - A statewide trend impacting the need for mental health services is that the rate of expenditures for Community Services and Support (CSS) and Workforce Education and Training (WET) increases as unemployment and foreclosures increase.
 - For CSS, PEI, and WET, the DMH policy to weight funding to provide a baseline level for the smallest counties resulted in a trend toward higher per-capita expenditure in the smallest counties.
- There were multiple results for the implementation of CSS across the state.
- The statewide requirement to direct the majority of CSS money on FSPs was met.
- FSP findings were:
 - As of FY 2008/09, all counties and one municipality were expending funds on FSPs.
 - In FY 2006/07, counties and municipalities relied more heavily on county staff to implement FSPs.

- The proportion of expenditures shifted to contractors in later implementation years.
- As of FY 2008/09, the majority of counties/municipalities were expending monies on Outreach and Engagement.
- Three out of four counties expending funds under “General System Development” documented a specific strategy implemented.
- There were multiple findings for WET and PEI.
- Most technology funds were expended on projects rather than administration, whereas most capital facilities funds were expended on administration or projects.
- Among the counties and municipalities who launched Capitol Facilities and/or Technological Needs efforts tended to focus their efforts on a single project.
- The individual level (client) data will greatly strengthen the Follow Up Report, in terms of the ability to tie cost data to client impact.
- Dates for the next steps were supplied.
- The reports presented today are available for download from the MHSA and UCLA websites.

In response to a question from Commissioner Vega, Ms. Harris stated that the Revenue and Expenditure Report (RER) was used to calculate expended funds. Tying in the cost report data and other sources of verification would have provided a better picture of expenditures, but this data was not accessible at the time of this report. It will be available for the next report. The RER data is based on what the counties have submitted to DMH. Commissioner Vega voiced concern that counties have not been able to expend their allocations as they planned to. It is important for the MHSOAC, in its oversight role, to monitor this.

Ms. Harris added that one of the most exciting deliverables to come is a master data source that combines four to five data sources into one data set that the MHSOAC will have access to. The RER, cost reports, annual plan updates, and component allocations will all be included in this master data set.

Commissioner Poat noted that the year 2012 will be the year for the Commission to organize all of this data into some comprehensible message about what is happening in the system. He suggested that the Commission prepare for this effort by discussing expectations and framing options on how to deal with the mountain of data. The Commission may need to meet and act outside of the formal Commission setting.

In response to a question from Commissioner Vega, Ms. Harris explained that in the RER, unexpended funds did not include Prudent Reserve, although it does appear that some counties might have included Prudent Reserve in their carryover from previous years. She recommended that Prudent Reserve be specifically documented as its own line item.

Public Comment

- Dr. V. Diane Woods, President and Chief Executive Officer of the African American Health Institute of San Bernardino County and the Project Director of the California Reducing Disparities Project (CRDP): African American Strategic Planning Workgroup (SPW), commented that this is a very critical issue related to county level expenditure of funds, especially to ethnic populations. She asked whether the researchers would be able to identify how much money went to contractors that were ethnic minorities hired to implement FSPs.
- Mr. Jim Gilmer, MHSOAC Services Committee, agreed with Dr. Woods' comment. One of the barriers to reducing racial and ethnic disparities is in decision making relative to funds distribution, including contractors in the community. Also, another critical factor is implementing community-defined evidence and promising practices so that racial and ethnic disparities are being reduced.

Chair Poaster agreed with the importance of these points. This report is the first time anyone has looked at how much money is spent and where it is spent. This is a baseline and not the finish line. Vice-Chair Van Horn added that we do not have data on whether particular agencies are ethnic agencies at this point.

9. General Public Comment

- Mr. Gilmer, speaking on the PEI Trends Report presentation, stressed the need to focus on racial and ethnic communities by digging down with hardcore data, as a means of reducing disparities.
- Ms. Derby commented that it is essential that PEI also focus on people already diagnosed with severe mental health conditions, and that these populations not be excluded from these services. She also asked for clarification on whether consumer/family members and representatives of underserved groups will be part of the regulation discussion at the September 29 meeting.

Chair Poaster responded that it has been the adopted position of the Commission, as stated in the AB 100 Workgroup Report, that those individuals would be part of that process.

- Ms. Vickie Mendoza, United Advocates for Children and Families (UACF), addressed the data that Dr. Lee presented: 98 percent of family members and 80 percent of clients were involved. Sometimes family partners and family voice are included as part of data results when their presence was not really that strong. Also, family voice has not been a part of Realignment involvement because families and UACF do not understand it. More time is needed to educate the family members and clients on Realignment.
- Ms. Beatrice Lee, Executive Director of Community Health for Asian Americans (CHAA) and President of REMHDCO, reported that MHSA funds in Alameda County are being used for underserved, unserved, and minority communities. New communities such as Mongolian, Burmese, Bhutanese refugees, Tibetan and Pacific Islanders now have services that include community advocates, as a result of MHSA funding.

10. Closed Session – Government Code Section 11126(a)

The Commissioners adjourned into closed executive session. No reportable action was taken.

11. MHSOAC Executive Director Report

Update on State Reorganization Activities

Executive Director Gauger reminded everyone that there continues to be numerous efforts underway related to the reorganization of mental health system functions. Many of the proposals create substantial changes to the mental health system, and to the Commission and its role moving forward.

Executive Director Gauger provided an update on some of the activities currently underway, summarized below.

- During the past summer, the State administration has been seeking input from stakeholders on the three bills signed by the Governor in 2011.
- Medi-Cal related functions will be transferred from DMH and ADP to the Department of Health Care Services (DHCS). Some of the Medi-Cal specialty mental health functions being transferred to DHCS are Medi-Cal program compliance, county technical assistance, Information Technology and data management support, and policy, administrative, and financial services support for all Medi-Cal programs.
- DMH convened a series of stakeholder meetings to gather feedback on the non-Medi-Cal activities that will have to find a home when DMH is eliminated. The many findings included the following:
 - State level executive leadership for community mental health is essential.
 - Oversight is the most important state mental health function.
 - Program evaluation and quality improvement are essential.

- Effective financial oversight is a high priority.
- Stakeholders voiced hope for streamlined reporting requirements and centralized audit activities.
- Executive Director Gauger listed DMH next steps that include monthly stakeholder meetings.
- DMH included the MHSOAC's "Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment" as an appendix to its report going to the Administration.
- An issue is still pending: will ADP/DMH non-Medi-Cal mental health functions be integrated into DHCS or given to a separate department?

Commissioner Poat stated that the Commission would want something on its January agenda that would evaluate what is in the Governor's Budget Proposal, because that is probably the next most reliable projection of what will take place.

In response to a question from Chair Poaster, Executive Director Gauger stated that MHSOAC staff had not participated in the development of the DMH stakeholder process.

12. Mental Health Funding and Policy Committee

Prudent Reserve Policy – Committee Recommendations Regarding Strategies to Monitor Prudent Reserve and Provide Report in 2014

Commissioner Poat stated that the Committee would give its recommendation on this emerging policy issue. The presentation is summarized below.

- The Mental Health Funding and Policy Committee was asked to develop strategies to permit oversight of prudent reserve consistent with AB 100 policy changes.
- MHSA requires local prudent reserves to ensure continued services under CSS and PEI. The source of funds is highly volatile; the prudent reserve is meant to be used when revenues are low.
- DMH Information Notice established a 50 percent reserve for any program providing direct services – CSS and PEI – to Californians.
- The requirement to fund prudent reserve was suspended beginning in FY 2010/11 due to statewide economic conditions.
- Since the original policy was developed, the adoption of AB 100, eliminated the state plan review and approval.
- AB 100 made no statutory changes to prudent reserve requirements, and no statutory changes to the local review process of County Plan updates.

- Currently the biggest challenge is the availability and accuracy of data, as to how much money is in each county's reserve. We need to get to an adopted shared framework between the counties, the State, and everyone else for the information we want, when we want it. Commissioner Poat's key message is that we do not yet have that framework in place.
- All counties have established a prudent reserve, the total of which is estimated at \$279.3 million.
- As of June 30, 2011, five counties had accessed reserves for a total of \$3.8 million. The small number of counties likely reflects other account balances being used for one-time available money.
- Current identified data sources have limitations that make it difficult to determine accurately the prudent reserve balance.
- Possible new data sources include the RER and County Auditor Controller fund certification.
- Commissioner Wooton explained the Committee recommendations, which was to ensure transparency, stakeholder engagement, and effectiveness. The recommendations also describe actions for the Funding and Policy Committee to take regarding monitoring local prudent reserves and providing a report with summary data on how the funds are being utilized.

Innovation Reversion – Committee Recommendations Regarding Possible Reversion Policy Change

Commissioner Poat stated that under existing procedures, local funds up to \$142 million as of June 30, 2012 could be redistributed out of Innovation funding primarily to CSS and PEI programs. He presented an explanation of why that would happen, and options to intervene.

- There were large allocations of Innovation funds available from FY 2008/09 through FY 2010/11, and a dramatic decrease in FY 2011/12 and for the foreseeable future.
- Innovation programs can be designed for periods in excess of three years, which is important because innovation involves looking at problems and developing solutions. An Innovation program needs more time than a program that is already a demonstrated success.
- The Reversion Policy was established by the Act, which the voters adopted. The policy was designed to "use or lose" funds. The Act established timeframes of three years for CSS, PEI, and Innovation (INN); and ten years for Capital Facilities/Technological Needs and WET.
- Over \$310 million was collected through FY 2010/11. Reversion dates extend from June 30, 2012 through June 30, 2014.

- The statewide amount of these funds which are at risk of reversion is unknown because county projected expenditure information is not reported to the State. This could be made part of the future reporting requirement, so that the Commission is in a position to know the balance.
- The funds are unspent because of INN implementation delays; also, many counties are concerned about being able to expend the large sums of INN funding available from FY 2008/09 through FY 2010/11.
- CMHDA has a proposal stating that looking at INN funds within the broader perspective of the CSS and PEI funding pots, and making the expenditure calculations within that broader configuration, results in leaving the money with the counties. They will have the opportunity to spend it on INN purposes.
- The revised calculation of INN reversion allows counties to plan for longer INN programs (necessary because they are new), within the context of their overall MHSA Plan.

Questions

Commissioner Vega asked a question on behalf of the counties: How does MHSOAC serve its oversight role with regard to INN funds, as they now are going to be rolled into CSS and PEI funds? Commissioner Poat responded that if MHSOAC adopts the proposed motion and proceeds with the CMHDA proposal, the money would be retained for INN. Otherwise, the money will revert back into the CSS and PEI fund source.

Chair Poaster added that this particular proposal is simply a way of calculating the funds that are eligible for reversion.

Public Comment

- Ms. Brody stated that the California Network of Mental Health Clients strongly supports this proposal to change the calculations for reversion of Innovation funding. The Innovation component is extremely important to mental health clients across the state. Many peer-run programs are being developed through Innovation and they are crucial.
- Ms. Derby commented that the information presented seemed reasonable to ensure that counties have the time to develop these programs and move forward with them. She was concerned, as was Commissioner Vega, that there would be tracking of the funds so that they would remain available for Innovation purposes, as expressed in the Act.

Ms. Derby also commented that NAMI California stressed the importance, with the change in policy with AB 100, of involving local stakeholders in the discussion leading toward development of the prudent reserve policy.

- Ms. Sharon Lyle, consumer, expressed her concern that so many consumers are not getting their needs met, particularly the underserved ethnic populations. Instead of focusing on Innovation funds, the Commission should be concerned that needs are not being addressed. Consumers should not have to advocate for themselves the way she has. Commissioners should use simple language and business practices, and take care of the neediest.
- Mr. Frank Topping, Secretary of the Sacramento County Mental Health Board, commented that we have taken much time, since the Act was written and requested consumer input, to develop Innovation programs. He asked the Commission to preserve the work that the counties have put into their Innovation programs.
- Ms. Hart asked for clarity, in laymen's terms, on what the Commissioners were presenting. Innovation gave the faith base an opportunity to participate; the faith base is a component that addresses many of the issues out in the communities, especially the African American community.

Commission Discussion

Commissioner Brown expressed concern with the Commission's lack of authority in ensuring compliance. Commissioner Poat agreed, and noted that the mention of having the Executive Director keep the Commission engaged in the evolving environment was due to this issue.

Vice-Chair Van Horn stated that this is the first of several sequential motions over the next three Commission Meetings. By March the Commission will have a better idea about where the factors (other than Medi-Cal) are headed, at which point the Commission will need to take a strong position to ensure that there is a way to review these reserve funds. Adopting the motions today will get us on track.

Chair Poaster agreed with the comments of Vice-Chair Van Horn.

The Commissioners agreed to amend the word "ensure" in the committee recommendations on prudent reserve to "champion."

Motion: *Upon motion by Commissioner Vega, seconded by Vice-Chair Van Horn, the MHSOAC voted unanimously to adopt the Mental Health Funding and Policy Committee's recommendations (as amended) regarding oversight of Prudent Reserve as stated below:*

The Commission should:

- *Champion transparency of all Prudent Reserve funding and expenditure decisions made by counties.*
- *Champion stakeholder engagement in county decisions to augment and use Prudent Reserve.*
- *Assure taxpayers that the revised policy is the most effective policy moving forward.*

The Funding and Policy Committee should:

- *Monitor the local Prudent Reserves and other allowable transfers from CSS by
 - *The level and amount of funds deposited and withdrawn from the local Prudent Reserves by year by county*
 - *The amounts of CSS funds transferred to Capital Facilities and Technological Needs (CF/TN) and Workforce Education and Training (WET)**
- *Provide a report to the Commission in the summer of 2014 capturing the information listed above*
- *Provide summary data of how Prudent Reserve is being utilized*

Chair Poaster preferred for the Commission to make a stronger statement in the Innovation reversion motion – to include the point that significant damage would be done to two or three years' worth of efforts on Innovation programs.

The Commissioners discussed the wording of the motion.

Motion: *Upon motion by Commissioner Poat, seconded by Vice-Chair Van Horn the MHSOAC voted unanimously to approve the policies below:*

- 1) *The MHSOAC strongly supports the proposed revised calculation of Innovation Reversion as presented and urges the California Department of Mental Health to also support it.*
- 2) *The MHSOAC directs the Executive Director to urgently communicate to the California Department of Mental Health and to advocate for the implementation of the revised Innovation reversion calculation and report back to the Commission at the November 2011 meeting.*

12. Cultural and Linguistic Competence Committee

Report on the Progress of the Reducing Disparities Strategic Planning

Vice-Chair Van Horn stated that the Commission is now beginning to get semi-annual reports on the progress of the Reducing Disparities Strategic Planning. The Strategic Plan comes in mid-year 2012, and then the Commission will have four years of projects funded through the statewide grants to put the Reducing Disparities Plan into operation.

Mr. Sean Tracy, DMH, presented the semi-annual report on the California Reducing Disparities Project (CRDP). Below are highlights.

- *Community Defined Evidence* is a key statewide policy initiative to improve access, quality of care, and outcomes for racial, ethnic, and cultural communities.
- Mr. Tracy gave a background of the project.

- The CRDP Vision is *“Service delivery defined by multicultural communities for multicultural communities.”* The MHSOAC gives approval on utilization of state resources.
- CRDP structure was shown in an organization chart. The five workgroups represent the Latino; Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ); African American; Native American; and Asian/Pacific Islander communities. All will develop population reports.
- With the Support Team, the workgroups had five activity outcomes:
 - They engaged their respective communities throughout the state.
 - They convened focus groups in various regional areas.
 - They conducted key informant and cultural broker interviews to identify community strengths.
 - They developed community needs assessments.
 - They participated on mental health committees.
- Mr. Tracy provided project timelines.
- CRDP is seeking MHSOAC support of the \$1.5 million of ongoing state-administrative MHSA funds (annually).
- Another CRDP issue for MHSOAC direction is the \$56 million instead of the \$60 million that everyone thought was available for CRDP action.

Chair Poaster and Vice Chair Van Horn discussed with Mr. Tracy the error that resulted in the \$60 million that the MHSOAC originally voted for the California Reducing Disparities Project (CRDP) being reduced to \$56 million. The Commission voted for \$60 million and \$60 million should have been reserved. Vice Chair Van Horn asked whether DMH would get the \$4 million out of next year’s PEI allocation since the CRDP will not start until mid-2013. Mr. Tracy stated the Department would like to work with the Commission to make sure the \$4 million error is fixed.

Commissioner Vega expressed the hope that at some point, the Commission would include, within the scope of groups that have not been served, people with sensory disabilities outside of mental health issues. Those with deafness and blindness are hugely impacted disparately by mental health conditions.

Public Comment

- Mr. Rubin Cantu, California Pan-Ethnic Health Network (CPEHN), emphasized the importance of this project and how far-reaching it is going to be; it is the first of its kind. The strategic planning workgroups have reached thousands of people to garner input into the project. In California, almost 60 percent of the population is people of color; when the LGBTQ community is added, the number is much higher.

- Ms. Hiramoto addressed Commissioner Vega's comment. The California Multi-Cultural Commission provides outreach to people with sensory disabilities and it is inclusive of all underserved communities.

Ms. Hiramoto also asked the Commission to review its record of the motion several years ago regarding the administration of the PEI statewide projects. She had clarified then with the Commission that it was only to pertain to the Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction projects.

- Ms. Derby stated that NAMI California strongly supports the efforts of the CRDP and its leadership by the Office of Multicultural Services (OMS). She encouraged the Commissioners to read through the policy statement in their packets.
- Mr. Gilmer commented that you can not go forward without remembering where you have come from. When Proposition 63 was originally announced, it was a dream to people from communities of color and those with sensory disabilities. It brought people out. Those people have vanished over the last six years until now, with the establishment of Strategic Planning Workgroups (SPWs). Reducing disparities should be a concept integrated into planning and recommendations across the system.
- Ms. Lyle asked for more assistance and stressed that the unmet needs of people like her are severe.
- Ms. Lee highlighted what REMHDCO has learned so far in participating in shaping this initiative. The transformation of the mental health system in California requires a multi-pronged approach, using strategies relevant at the local county level, the regional level, and the State level.
- Ms. Rachel Guerrero, community member and consultant, reminded the Commissioners that this is truly an extraordinary effort in California. The amount of work that the five cultural-specific organizations have amassed in the past two years is huge. There are two pivotal points in the rollout of this project:
 1. There really was inclusion by the five communities when they went out and got this information.
 2. When the Strategic Plans are submitted and sent to the DMH and MHSOAC, the design of the next phase is critical.
- Ms. Maribella Sala, UC Davis Center for Reducing Disparities, commented that the people who participated in the forums want to see that the resources from MHSA come down into the community. They participated in the PEI process and they do not feel that their voices were heard or their concerns addressed.

- Ms. Brody stated that CNMHC highly values and wishes to prioritize the work of the CRDP. CNMHC wants to ensure that the OMS remains at the helm of the program, although it is looking at an uncertain transition along with DMH.
- Ms. Janet King, Native American SPW, commented that the CRDP has been the most robust stakeholder process she has seen yet. It was strategic to use representatives from the communities themselves to do the research. Too many times the communities say that those who conduct research ask ridiculous questions and then do not report back the people's replies in the plans. Ms. King asked the Commission to prioritize CRDP.
- Mr. Daniel Gould, Equality California Institute, commented that the CRDP project is historic for LGBTQ communities. There is no other part of the state systems of care that acknowledge that LGBTQ people exist. The project is deeply community-invented and grass-roots at its heart. Equality California Institute is not a service provider; it is an advocacy organization with political roots – that is why it is the ideal group to connect with the community to talk about these needs.
- Mr. Kurt Schweigman, Native American SPW, stated that Native Americans make up the smallest population of the five SPWs, but many of its mental health needs are highest. He shared that the overwhelming input from Native American tribes and urban Indian communities around the state is that a return to traditional and cultural Native American practices and activities can improve prevention and early intervention of mental health.

In addition, Mr. Schweigman shared the feedback that for so long, the majority of counties have underserved, or have not been culturally competent to serve, Native American needs. He recommended that the Native American community receive an equal share of the \$60 million.
- Dr. Woods impressed upon the Commission the urgency of clearly understanding that this project has national and international implications. For the African American population, there is not enough research available to understand their perspective, needs, and ideas. At present this project has utilized ten datasets in order to be able to collect the data and triangulate the perspective in order to understand it better.
- Dr. Rocco Cheng, Pacific Clinics, commented that not only California, but also the nation is already paying attention to this project. At SAMHSA's policy summit a few months ago they were asking about it, as were several other mental health organizations. Although the project is a community treatment, Dr. Cheng hoped the Commission would keep it at the statewide level, because in many counties the Asian/Pacific Islander population is ignored because the population percentage is too small.

13. Workforce Education and Training Progress Update

Mr. Brian Keefer, California Mental Health Planning Council (CMHPC), stated that the panel had put together a brief overview of state-level obligated WET activities that have been contracted through 2014; regional partnership WET activities; local county mental health department actions; and a panel discussion with local perspectives from Butte and San Bernardino Counties. Below is a summary of the presentation.

- The state-level WET goals were in general around the development of capacity.
- State-level WET activities fall into three categories: financial incentivization (loan assumption and stipends); training (encompassing the Physician Assistant and Residency programs); and technical assistance, which has been provided statewide, regionally, and locally.
- We have obligated about \$94 million with WET to lift off initiatives for behavioral health workforce capacity that we never really had an opportunity as a system to do. We have expended about \$61 million of that, and have been able to touch about 3,000 people in our workforce to retain them.
- The Planning Council, is trying to work with the Department and decide on future contracts and their total obligated amounts.

Ms. Adrienne Shilton, Project Manager, Local WET, CiMH, talked about regional partnership activity and local program highlights.

- There are five regional partnerships in California for each of the five regions. Each region has \$3.6 million. Counties, providers, consumers/family groups, and education come together to look at how to build the capacity of the public mental health workforce, including the diversity that we so desperately need.
- In the Central Valley region, where they have identified a need for more Master's level clinicians, the Central Valley partnership, as well as a number of counties, pooled their WET funds and created a Master of Social Work program with a rural mental health focus at California State University (CSU), Sacramento.
- The Central Valley partnership funded an online Nurse Practitioner/ Psychiatric Nurse Practitioner program.
- The Bay Area Region was the model for regional partnerships statewide. They have been meeting for ten years (pre-MHSA). Recently with their workforce dollars they pulled together a forum with county staff directors and Human Resources staff to look at how they can hire and promote staff within the county mental health system.

- In the Central Region much training is emerging. In small rural counties, it's difficult to provide high-quality evidence-based training, so they are pooling their funding to provide education for staff. They are also working on a core competency project for mental health staff.
- In the Los Angeles Region they are partnering with their local universities to look at evidence-based practices and research, particularly evidence-based practices adopted for culturally diverse communities.
- In the Southern Region they have created an online document detailing all of their mental health programs and certificate programs. They are also working on a core competencies project, and have contracted with University of Southern California to provide a skills-based cultural competency program for staff.
- In the Superior Region they have funded an online and hybrid BSW/MSW program integrating community colleges, CSU Humboldt, and CSU Chico. They have also brought together community colleges to look at issues around articulation.

Mr. Allan Rawland, MSW, Director, San Bernardino County Mental Health, spoke about WET in that county.

- Mr. Rawland invited the Commissioners and audience to a cultural competency summit in Ontario on November 2-3.
- The county has a post-competency step that occurs after a person earns academic competency and internship, and is employed in the agency. Post-competency evaluates the education to ensure that it is meeting the intent.
- Part of the WET planning process was to try to give the training program an identity. The training institute that was developed as part of the WET project is the foundation for the county's training initiative.
- Training and workforce development stretches across all the mental health funding streams. The county does blended funding; it doesn't isolate programs by funding source, but tries to do an integrated model with Children and Family Services, Workforce Development, Probation, Health Services, and Public Health. There is much cross-training, not just vertical training.
- The biggest challenge is to have enough bicultural and bilingual staff to meet the needs of the community.

Ms. Anne Robin, MFT, Director, Butte County Mental Health, spoke about that county.

- The vision for WET in Butte County includes increasing understanding and implementation of Recovery and Wellness Concepts, increasing cultural competence, and reducing dependence on external trainers and consultants.

- Butte County WET accomplishments include:
 - Using the WET Workforce Assessment, the county has been designated a mental health professional shortage area.
 - The county has purchased and implemented an electronic learning system for employees.
 - A countywide CIT program has been implemented and has 64 graduates.
 - Ongoing training and projects operationalize the concepts of recovery, wellness, and resiliency.
 - The county is building workforce capacity through ongoing job-specific training.
 - The county is developing a Cultural Competency Academy.
 - The county partnered with NAMI to train a team to implement the NAMI provider education training.
- Impacts of WET include an increase in morale (shown via Gallup Questionnaire); the initiation of regular ongoing meetings and stronger relationships between first responders and the county Department of Behavioral Health; and new employee orientation.

14. Client and Family Leadership Committee – *The “Report Findings from 2010 Community Forums” agenda item was postponed until the November Commission meeting due to lack of time.*

15. General Public Comment

- Ms. Hiramoto commented that it would be beneficial for the Commissioners to hear what committee members wish to include in their charters. Committee members have much to offer and have some good suggestions.

Chair Poaster noted that staff has begun identifying elements for the overall Commission Workplan. They will then be working with committee chairs to identify particular issues. Chairs will then bring the draft charter to each of the committees for discussion, looking at the overall Commission Workplan. The committees will fine-tune the charters and send them back to the Commission for approval.

Chair Poaster hoped for an expedited process for the committees to come up with charters. The overall Workplan will be done as part of a regular Commission meeting. It is what drives the charters.

- Ms. Hart commented that each Commissioner has a charge and the decisions they make impact thousands of people. On her way home, she will say a prayer for wisdom for each Commissioner.

- Dr. Woods commented that many in attendance have come from Southern California on their own resources. She requested that when working with people of African American ancestry, visibility is important. These audience members had risen very early and would return home very late. They appreciate the decisions that the Commission is making.

Dr. Woods added that they are releasing the African American population draft report this month for 30-day review. It is comprehensive: people wanted to tell the whole story. Chair Poat ensured with Dr. Woods that she would send a copy to the MHSOAC.

- Mr. Steve Leoni commented on the prudent reserve. In changing the word “ensure” to “champion,” the words “strongly support” could also be considered.
- Ms. Lyle read to the Commissioners some of the issues that those with disabilities face: being ignored, dehumanizing social encounters, oppression, miscategorization, inter-generational traumatic experience, ongoing micro-aggression, perpetual social-imposed negative marginalization, ongoing abuse and stress, overt and covert racism, benign neglect, personal unresolved identity issues, lack of accurate mental health assessment, over-prescribed medication, lack of medical follow-up, etc.

Ms. Lyle thanked the Commissioners for their support because the Commission can make a difference.

16. **Adjournment**

Chair Poaster adjourned the meeting at 4:48 p.m.