



**State of California**

**MENTAL HEALTH SERVICES  
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting  
November 20, 2014

MHSOAC  
1325 J Street, Suite 1700  
Sacramento, California 95814

866-817-6550; Code 3190377

**Members Participating**

Richard Van Horn, Chair  
David Pating, M.D., Vice Chair  
Khatera Aslami-Tamplen  
John Buck  
Victor Carrion, M.D.  
David Gordon  
Paul Keith, M.D.  
Christopher Miller-Cole, Psy.D.  
Ralph Nelson, Jr., M.D.  
Larry Poaster, Ph.D.

**Members Absent**

John Boyd, Psy.D.  
Sheriff William Brown  
Senator Lou Correa  
Assemblymember Bonnie Lowenthal  
Tina Wooton

**Staff Present**

Sherri Gauger, Interim Executive Director  
Kevin Hoffman, Deputy Executive Director  
Filomena Yeroshek, Chief Counsel  
Renay Bradley, Ph.D., Director of Research and Evaluation  
Deborah Lee, Ph.D., Consulting Psychologist  
Lauren Quintero, Manager  
Kristal Carter, Staff Services Analyst  
Cody Scott, Office Technician

**1. CALL TO ORDER AND ROLL CALL**

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:30 a.m. and welcomed everyone. Kristal Carter, Staff Services Analyst, called the roll and announced a quorum was present.

**Chairperson's Remarks**

Chair Van Horn asked the incoming Chair to name his Committee Chairs and Vice Chairs.

Commissioner Carrion thanked the Commissioners who will work in this capacity. He announced the chairs and vice chairs for next year:

Client and Family Leadership Committee:

- Chair: Ralph Nelson
- Vice Chair: Vacant

Cultural and Linguistic Competence Committee:

- Chair: Khatera Aslami-Tamplen
- Vice Chair: Tina Wooton

Evaluation Committee:

- Chair: Richard Van Horn
- Vice Chair: Paul Keith

Financial Oversight Committee:

- Chair: John Boyd
- Vice Chair: John Buck

Services Committee:

- Co-Chair: Christopher Miller-Cole
- Co-Chair: Tina Wooton
- Vice Chair: Dave Gordon

**ACTION**

**1A: Approve October 23, 2014, MHSOAC Meeting Minutes**

Commissioner Poaster asked to add “People should not be shocked if providers and counties are unable to meet the requirements of this section until there is a new data system, which would prevent them from having to triple entry depending on what the funding source is” in reference to his comment on page 9 about the disaggregation of data.

Action: Commissioner Keith made a motion, seconded by Commissioner Miller-Cole, that:

*The MHSOAC approves the October 23, 2014, Meeting Minutes as amended.*

Motion carried, 10-0

**INFORMATIONAL**

**1B: October 23, 2014, Motion Summary**

**1C: MHSOAC Evaluation Dashboard**

**1D: MHSOAC Plan Review Dashboard**

**1E: MHSOAC Calendar**

**ACTION**

**2A: 2015 MHSOAC Work Plan**

**Presenter:**

**Sherri Gauger, MHSOAC Interim Executive Director**

Ms. Gauger provided an account of the 2014 Work Plan and an overview of the 2015 Work Plan, emphasizing that 2015 includes an additional focus on building the data infrastructure to support statewide evaluations and communicating to all Californians the services and outcomes of Proposition 63. She reviewed the eight high-level priorities and their activities to be accomplished in 2015.

## **Commissioner Questions and Discussion:**

Chair Van Horn asked how the Department of Health Care Services (DHCS) is progressing on the rest of the regulation package.

Filomena Yeroshek stated staff have not been notified of any amendments or discussions regarding the Community Services and Support (CSS) Regulations.

Chair Van Horn stated the need to contact Karen Baylor, because if the MHSOAC regulations are out too far in advance of theirs, there will be cross-over problems.

Ms. Gauger stated she and Ms. Baylor meet every two weeks to keep Ms. Baylor apprised of the Commission's Prevention and Early Intervention (PEI) and Innovation (INN) Regulations progress. Last week, Ms. Baylor discussed revenue and expenditure requirements that were put into the regulations.

Commissioner Poaster asked if there was any regulatory activity occurring regarding the Workforce Education and Training (WET) programs.

Ms. Gauger stated staff had been informed that the Office of Statewide Health Planning and Development (OSHPD) was going to begin the regulatory process for the WET component of the Act. The OSHPD does not have regulatory authority, but is working in collaboration with and under the leadership of the DHCS.

Chair Van Horn asked, under Priority 2(E): Participate in Peer Certification process, if there was any movement on the peer certification process.

Ms. Gauger stated there has not been a response to the Commission's letter to the California Mental Health Planning Council (CMHPC) yet. She offered to follow up with them.

Commissioner Miller-Cole asked about "dedicated funding" with regard to Priority 7: Communicate effectively the statewide impact of the MHSA with a strategic marketing campaign and dedicated funding; and Priority 8: Promote and implement strategies that overcome the stigma and discrimination associated with mental illness by executing a strategic marketing campaign with dedicated funding.

Ms. Gauger stated the Commission will continue to pursue additional resources for this effort. For the past three years, there have been surplus funds at the end of the year. She stated the plan to set aside \$500,000 at the beginning of each fiscal year as the Communications Department budget instead of projecting the surplus funding each quarter and expending the funds in increments.

Commissioner Gordon requested that the schools' early intervention project that the Services Committee has discussed be included as Priority 2(M): Collaborate with state and local school districts and county mental health leaders on a pilot to provide early mental health intervention services in preschools and K-12 schools throughout the state. He offered to work with staff on the necessary language.

Commissioner Poaster asked how the Commission would be involved in providing resources for public information.

Ms. Gauger stated that the Communication's strategic plan would be brought to the Commission for approval.

Vice Chair Pating stated the Commission has been talking about several things that could be rolled up into a communications plan. The Commission has never had funding for things like this previously.

Commissioner Poaster agreed and stated, since the Commission is going to establish the funding for it, there should be some way of using the Commission's strength and resources to help.

Ms. Gauger stated the Commission will look at internal resources, at least temporarily, for getting the Resource Center up and running. Some of the funds that have been dedicated to improving the DHCS data systems in the past can be redirected to building the Commission's data system and Resource Center.

Commissioner Carrion stated this is an important investment because the more Californians know about Proposition 63, the safer the funds will become so the work can continue. Presently, many individuals who benefit from Proposition 63 are still unaware of its existence.

Vice Chair Pating asked if Priority 1(C): Collaborate with the DHCS on performance outcomes for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), was an issue for the California Mental Health Planning Council (CMHPC) or the Children's System of Care.

Ms. Gauger stated the DHCS reached out to Dr. Renay Bradley, the Director of Research and Evaluation, because some of the Commission's evaluation indicators would be equally appropriate to what they were doing. The DHCS wanted to ensure the two organizations were communicating.

Vice Chair Pating asked staff to look at Priority 4: Ensure that the perspective and participation of diverse community members is reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of the Commission's decisions and recommendations. The Commission will hear from the six Strategic Planning Workgroups (SPWs) today on their diversity plans. These work groups are well established and have had three years of experience working together. This community sampling can give the Commission an organized and coherent response because they have pulled together for the past three years providing that message. He recommended working with the Office of Health Equity (OHE) to figure out how to sustain and utilize them as an ongoing resource.

**Public Comment:**

Pete LaFollette addressed the issues of lack of data, central governing authorities for counties, and an effective designated stakeholder consumer voice for formation of policy. He stated he has a consumer database he has been keeping since 2004, but it is not referred to because it is not flattering. The 2014 Master Plan did not adequately represent stakeholder, consumer, and family member feedback. He stated the need for more integration between consumers and family members and the Commission.

Patricia Wentzel, of the National Alliance on Mental Illness (NAMI) California, referenced Priorities 1(F): Conduct additional evaluation of Community Program Planning processes, and 3(D): Continue to provide oversight of the Reducing Disparities Statewide Strategic Plan and Phase 2 projects, and stated the need to include the disability community in assessing for disparities. They are difficult to assess because they are not receiving services and do not attend forums and meetings. She suggested holding a community forum in Los Angeles specifically for the deaf community. In reference to Priority 8: Promote and implement strategies that overcome the stigma and discrimination associated with mental illness by executing a strategic marketing campaign with dedicated funding, she asked to what extent the communication efforts are being made in a culturally-appropriate way to all communities, including the deaf and blind communities.

Commissioner Carrion asked if the Commission has representation for the deaf and blind communities in the Committees.

Commissioner Aslami-Tamplen offered to bring it to the attention of the Cultural and Linguistic Competence Committee (CLLC) next month when they discuss the Committee Work Plan.

Stacie Hiramoto, the Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked the Commission for the thoughtful and thorough Work Plan. She commended the Commission on Priority 4: Ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of the Commission's decisions and recommendations, in reaching out to the community. She stated she supported the previous speakers' testimony. She asked for forums for targeted focus groups where many people from underserved communities can feel comfortable, in addition to the large forums. In reference to Priority 5: Collect and track data and information, regarding data, she stated the hope that there is focus on data that measures reducing disparities. She suggested adding something about the county cultural competence plan reports. Ms. Hiramoto requested that the Work Plan go through a Committee before it comes before the full Commission so little issues could be taken care of at the Committee level.

Commissioner Nelson stated the Client and Family Leadership Committee (CFLC) has been looking at doing some type of targeted focus groups, possibly by themselves or with the community forums the day before, looking at different populations that might not come to the community forums. That is in process.

Action: Commissioner Poaster made a motion, seconded by Commissioner Keith, that:

*The Commission adopts the 2015 Mental Health Services Oversight and Accountability Commission Work Plan, with the addition of new Priority 2 M: "Collaborate with state and local school districts and county mental health leaders on a pilot to provide early mental health intervention services in preschools and K-12 schools throughout the state."*

Motion carried, 10-0

## **INFORMATIONAL**

### **3A: Cultural and Linguistic Competency Committee (CLCC): African American Faith-Based Presentation**

#### **Presenters:**

**Gigi Crowder, LE, Ethnic Services Manager, Alameda County Behavioral Health Care Services**

**Brian Hill, Founder and Chief Executive Officer, Brian's Online Success Services; Executive Director, Black Men Speak**

**Jeraniqua Martin**

**Reverend Dr. Oscar Wright, Chief Executive Officer, United Advocates for Children and Families (UACF)**

Gigi Crowder, the Ethnic Services Manager of the Alameda County Behavioral Health Care Services, stated she began this work twenty-five years ago and great progress has been made under the Mental Health Services Act (MHSA or Act). She provided an overview of the history, issues, key findings, objectives, and pilot communities of the African-American Spirituality Initiative. She stated when a faith leader speaks, people listen. Ms. Crowder showed a video on "Each Mind Matters."

Jeraniqua Martin, a consumer and advocate, shared, as a transition-age youth (TAY), why the African-American Spirituality Initiative is important to her.

Brian Hill, the Founder and Chief Executive Officer of Brian's Online Success Services and the Executive Director of Black Men Speak, asked the Commission to remember two things

about him: he is challenged yet inspired, and he must trust and surrender. These things equal faith. He provided examples of when those terms became meaningful in his life. Mr. Hill stated he has gone from his lived experience in the ghetto of Chicago to owning and running two companies and addressing the Commission today because of MHSA funds.

Reverend Dr. Oscar Wright, the Chief Executive Officer of the UACF, asked the question “Is there an intersection between race, culture, and spirituality”? He stated African Americans metabolize medication at a slower rate than average, meaning they can become overdosed and experience increased side effects. That is a nuance the typical clinician may not have access to. Many African Americans have a “healthy paranoia,” a defense mechanism, but it can be misdiagnosed as schizophrenia or bipolar. He stated the need to be adept to the nuances of mental health and how it impacts race, culture, and spirituality.

Spirituality is that universal coping mechanism that all people use to reduce stress and to answer life’s questions. That is why, in the African American community, sixty percent of the people who have mental illness go to their priest, rabbi, or pastor first before they will come into the system. There is no stigma with the pastor, but there could be stigma in the community. Rev. Dr. Wright stated the importance of training and education for pastors and their congregations. The UACF created Faith Share 360, which has three goals: to educate and train pastors and congregations on mental health symptoms and how to recognize them; to develop caring congregations that could provide emotional and spiritual support; and to pull it together statewide.

Rev. Dr. Wright shared the powerful spiritual principle of giving. When individuals give, they feel better. That is why spirituality is so important.

## **INFORMATIONAL**

### **4A: California Reducing Disparities Project (CRDP)**

#### **Presenters:**

**Janne Olson-Morgan, Assistant Secretary, California Health and Human Services Agency (CHHS)**

**Jahmal Miller, Deputy Director, Office of Health Equity, California Department of Public Health (CDPH)**

**Aimee Sisson, MD, MPH, Office of Health Equity (OHE) Public Health Medical Officer**

Janne Olson-Morgan, the Assistant Secretary of the CHHS, presented a status update on the California Reducing Disparities Project (CRDP) Strategic Plan, which builds upon the work of five population groups and provides guidance and input for the California Department of Public Health (CDPH) on how they should distribute the funding allocated to them under the MHSA to support mental health projects. She stated the plan is expected to go public tomorrow.

Jahmal Miller, the Deputy Director of the OHE at the CDPH, stated the focus areas he is looking to integrate into the OHE are how to get to the root cause of the health and mental health inequities seen across the country and across communities in the state of California, how to go upstream in the social determinants of health and mental health, and how to proactively focus on Prevention and Early Intervention (PEI). He stated the need to have a comprehensive, cross-sectional approach to addressing disparities. He stated he is honored that the OHE is taking the lead, but acknowledged that it cannot do it alone. It will require collaboration and partnership.

Mr. Miller stated the CRDP in and of itself will not solve many of the issues. It focuses on five population groups, but there are many other groups out there. He stated he looked forward to working with this Commission to think expansively, inclusively, and strategically about how to

build around the infrastructure of the CRDP to invest more to make a greater impact on populations and communities across the state. He stated, even though the CRDP Strategic Plan has been under review and will be released tomorrow, the OHE has made significant progress on Phase 2.

Aimee Sisson, MD, MPH, the OHE Public Health Medical Officer, reviewed the CRDP phases and provided an update to Phase 2 of the CRDP, including the plans and the progress made to date.

### **Commissioner Questions and Discussion:**

Commissioner Gordon asked if these would be procurements, grants, or contracts.

Dr. Sisson stated they are public procurements or solicitations. The OHE is operating under a public contracting code exemption while following as many of the public contracting code rules as possible. The technical assistance provider and the statewide evaluation team solicitations will be closer to Requests for Proposal (RFP). The pilot project will be closer to a Request for Application, more like a grant application process.

Commissioner Gordon asked about the timeline for getting these grants online.

Dr. Sisson stated the timeline has been under development while waiting approval of the public release of the Draft Strategic Plan. The funds should begin rolling out in early 2015.

Commissioner Carrion asked if there is a selection process with a list of criteria for the solicitation process.

Dr. Sisson stated the OHE is working with a consultant to develop the solicitations. The draft solicitations will be shared with the public to get public input on the qualifications and selection criteria to ensure it is right before the final solicitations go out. The first draft solicitation for the statewide evaluation team for public review will be ready soon.

Vice Chair Pating stated there is urgency to meeting disparities in ethnic communities and a priority related to getting the \$60 million out. Politics have been holding this up at all levels. He stated that participants need not strive for perfection, but instead to get this money out. The funds were approved in 2006. The statewide grants were approved in 2010 and the California Mental Health Services Authority (CalMHSA) was launched at that time. The CalMHSA is almost done with their statewide suicide prevention project, and the CRDP funds have not even begun to go out. This is a high-priority, high-disparity-population need across the state. He stated the need to take the responsibility of solving the problem and solving it with the funds that were assigned almost nine years ago.

Chair Van Horn agreed.

Mr. Miller also agreed and stated the origins of this project predated the existence of the OHE. He stated failure for this project is not an option, but there are many people who would love to see this pilot project fail. He stated he would rather take the proper amount of time to not only roll it out the right way, but to ensure that the qualitative and measureable assets of evaluating the effectiveness of these pilot projects are built in. Unfortunately, there is a precedent set in how to invest public funds to where people do not hold themselves accountable as to the results and outcomes once money is urgently put out on the streets. That is a disservice to the people that are served across the country.

Mr. Miller stated he takes a great sense of pride in what the OHE is doing to meticulously roll out this project the right way. Within the first quarter of 2015, when the OHE starts to roll out these dollars, there can be the utmost confidence that the infrastructure of Phase 2 that has been informed by the communities and the SPWs is embedded into the solicitation process, and that the OHE is held accountable, because \$60 million will not solve all issues, but is just

a start. He stated he shares Vice Chair Pating's sense of urgency, but he also wants to do it the right way.

#### **5A: California Reducing Disparities Project (CRDP) African American Strategic Plan**

**Presenters:**

**Jim Gilmer**  
**Nicki King, Ph.D.**

Jim Gilmer acknowledged all CRDP family members. He showed a video titled "We Ain't Crazy" about the challenges that face African American TAY.

Nicki King, Ph.D., cautioned against putting groups in silos or thinking of individuals as a bundle of symptoms rather than a human being with potential to give back to society and who has the right to say when a medication is not working for them. PEI funds must be targeted at the youngest potential recipients of mental health services. Dr. King stated sensitivity to cultures is critical to a cohesive society where individuals can offer their best.

#### **6A: California Reducing Disparities Project (CRDP) Asian/Pacific Islander Strategic Plan**

**Presenter:**

**Rocco Cheng, Ph.D.**

Rocco Cheng, Ph.D., provided an overview of the background, issues, challenges, community-defined strategies, findings, and recommendations outlined in the Asian/Pacific Islander Strategic Planning Workgroup (SPW) Population Report. He stated the need to consider the context, to use a mixed approach, and to disaggregate data. Dr. Cheng suggested having Southeast Asians as one group and separating Asian Indian and Other South Asians as another group. He highlighted two significant issues that came out of the three conferences held: the role of spirituality in PEI; treatment, and recovery; and the importance of including cultural heritage and family in service delivery.

#### **7A: California Reducing Disparities Project (CRDP) Latino Strategic Plan**

**Presenter:**

**Gustavo Loera, EdD**

Gustavo Loera, Ed.D., provided an overview of the background, issues, challenges, community-defined strategies, findings, and recommendations outlined in the Latino SPW Population Report. He stated Latinos trust cultural remedies as being more effective for them. Ventura County has begun work on community capacity-building and outreach and engagement, which is one of the recommendations in this report. The strength lies in the community; work should be done within the community and solutions should be built from within the community.

#### **8A: California Reducing Disparities Project (CRDP) Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) Strategic Plan**

**Presenter:**

**Poshi Mikalson**

Poshi Mikalson, of Mental Health American of Northern California, provided an overview of the background, issues, challenges, community-defined strategies, findings, and recommendations outlined in the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) SPW Population Report. She stated, in general, LGBTQ individuals are raised with racial, ethnic, and/or cultural identities, traditions, and norms, which influence not only how they experience

their sexual orientation or gender identity, but how they experience their life as a whole. As such, treating an individual as if they are only LGBTQ without considering their racial, ethnic, or cultural background will not produce culturally-competent services.

Commissioner Carrion asked if the research showed who the best trainers are.

Ms. Mikalson recommended that agencies and individuals that provide LGBTQ training should have community-based endorsements.

Commissioner Nelson asked, since training seems to be most essential, if there are programs to train masters-level and Ph.D.-level therapists that have appropriate courses in the educational program before they are licensed.

Ms. Mikalson stated, even though it is technically in the curriculum, it does not necessarily happen and it does not happen in a culturally-competent manner.

### **9A: California Reducing Disparities Project (CRDP) Native American Strategic Plan**

**Presenter:**

**Janet King**

Janet King provided an overview of the background, issues, challenges, community-defined strategies, findings, and recommendations outlined in the Native American SPW Population Report. She stated the main mental health need is the suffering from “legalized discrimination” and historical trauma. She noted the problems of being diagnosed with substance abuse or suicide, when they are responses to historical trauma and lack of access to culturally-based behavioral health. She pointed out that, contrary to mainstream thought about fidelity to the evidence-based practice model, the Native American community loves deviation and flexibility of models because what works in one community may not work in another community. There are differences between Native American communities and the relationships they have with counties.

### **10A: California Reducing Disparities Project (CRDP): California MHSA Multicultural Coalition (CMMC)**

**Presenter:**

**Ahmed Nemr**

Ahmed Nemr, of the CMMC, provided an overview of the background, purpose, and accomplishments of the CMMC, which is a project of the REMHDCO, and its work with the SPWs and the CRDP.

Chair Van Horn asked for clarification on Southwest Asian communities.

Mr. Nemr stated this includes Afghanistan, Pakistan, and some Arab peoples, as well. They have different cultures, language, and religions.

Commissioner Buck asked how the organizations are connected.

Stacie Hiramoto stated the REMHDCO holds the contract for the CMMC. The Office of Multicultural Services was under the Department of Mental Health and was the originator and manager of the CRDP. The MHSOAC provided the funding. When the Department of Mental Health was reorganized, most of the staff went to the OHE, which is now managing the CRDP.

Commissioner Buck asked for clarification on the RFP.

Ms. Hiramoto stated the Office of Multicultural Services put the initial design of the RFP out to the community. The community asked that it be broken up so a variety of communities could have an opportunity to participate in the CRDP. She commended the Office of

Multicultural Services for listening to the community. This is unique in that the voices of underserved communities are being heard statewide.

Vice Chair Pating asked if there will be funds to allow the seven RFPs to continue meeting.

Ms. Hiramoto stated the CMMC will continue for another year. The seven SPWs are members of the CMMC and can continue in that capacity.

**11A: California Reducing Disparities Project (CRDP): California Pan-Ethnic Health Network (CPEHN)**

**Presenter:**

**Ruben Cantu**

Ruben Cantu, the Program Director of the CPEHN, stated the CPEHN is the organization that has taken the lead on developing the Statewide Strategic Plan to Reduce Mental Health Disparities. He provided an overview of the background and mission of the CPEHN, and the background, next steps, and timeline of the CRDP. Mr. Cantu summarized the four overarching themes, five goals, and twenty-five long-term strategies in the synthesized report.

Mr. Cantu stated the CRDP was a community effort with over 7,000 stakeholders involved in the process. He emphasized that the mental health system goes many directions, but the hope is that the CRDP Strategic Plan will guide the mental health system into one where there is a clear pathway for people to receive the services that they need to receive.

Mr. Cantu stated the CPEHN pulled together the recommendations and strategies highlighted in the five population reports and developed the vision for reducing mental health disparities in the state and transforming the mental health system into one that better meets the needs of the majority of Californians.

Commissioner Gordon asked how the CRDP fits into the whole health system, not just the mental health system, to improve access to services.

Marina Augusto, the Staff Services Manager of the OHE, CDPH, stated the CRDP is just a portion of the projects that the OHE is working on with MHSA dollars. The OHE is also mandated to develop a statewide plan that promotes health equity. In that statewide plan, there is a list of components that deals with the social determinants of health and includes disparities. It is a parallel process that intersects with the work of the MHSA under the CRDP. The OHE is working collaboratively with many state departments.

Commissioner Gordon suggested portraying that more generally in the materials, so that people see the whole scope of the issue.

Mr. Cantu agreed that all of these issues are interrelated. That is the approach the CPEHN is taking with the CRDP, as well.

Commissioner Poaster stated the Final Strategic Plan will be released in about four months. He asked about the timeline to distribute the money.

Ms. Augusto stated the plan is to begin issuing solicitations in January 2015, before the finalization of the strategic plan.

**GENERAL PUBLIC COMMENT**

Mr. LaFollette suggested that the Commission look at the PowerPoint from University of California (UC), Davis, titled "Collaborating with Underserved Communities." The MHSA was legislated to have a mental health recovery model working alongside and augmenting medical treatment. That continues to be short shifted and has failing outcomes. Pertaining to job creation, reducing disparities, and prevention, the MHSA was to provide measurable, positive,

established outcomes with recovery in mind. When it is not put on a fast track, then the outcomes do not happen and the MHSA continues to be a “train that has not left the station.” Surprising results happen when the MHSA helps with housing, jobs, and self-determination. With this encouragement and with tools, even the seriously mentally ill can and do recover, and that is the whole idea.

Ms. Crowder stated her concern that 25 percent of the \$60 million will go to evaluation, when many of the practices have already been in place. The need to validate them at such a high rate takes away from the money for treatment. She asked the Commission to reconsider this amount for evaluation. People continue to suffer while practices are tested that have already been proven to be helpful and working.

Ms. Hiramoto thanked the Commission for allowing this presentation. She gave the reminder that the strategic plan is not just for the \$60 million. It is a blueprint for the five underserved communities, but the plan can be used at the local or state level. She commended the OHE for working with the community.

Janet King echoed Ms. Hiramoto’s comments.

Laurel Benhamida, Ph.D., stated defining the data categories for race, ethnicity, culture, and language in the PEI Regulations and other Commission work, the OHE, the DHCS, and the CHHS, needs consultation of the mental health professionals with sociologists, anthropologists, linguists, and the community members from those groups, as well as area studies experts. She requested the addition of a category for those arriving suddenly in large numbers with great needs. This would give a regulatory incentive for counties to reach out to these newer arrivals at risk without waiting for threshold language requirements to be met.

Dr. Benhamida announced a prestigious international conference on stigma in February, and stated she would like to see California and the Commission lead by example. Those international experts know about these categories and how to define them in best practices, so they will be looking to see how California is doing it.

Anqunett Fazil, of Christian Partnerships, Inc. (CPI), emphasized the importance of collaborative efforts to do trauma-informed care. Trauma-informed care must be included in the strategies because there are many things that overlap. CPI just received a grant from the California Endowment to go into this more extensively. The community of mental health providers and policy makers must be in position, because in August 2015, the schools will begin doing this. She stated the need to combine resources to accomplish more.

Ms. Mikalson thanked the Commission and the OHE. She echoed Dr. Benhamida’s and Ms. Fazil’s comments. She invited the Commission to the LGBTQ Community Forum tonight at 6:00 p.m. at 2800 L Street in Sacramento.

## **INFORMATIONAL**

### **12A: California Mental Health Services Authority (CalMHSA) Update**

**Presenter:**

**Maureen F. Bauman, LCSW, MPA**

Maureen Bauman, LCSW, MPA, the Vice President of CalMHSA, provided an overview of the background and funding of CalMHSA and provided an update on evaluation and findings in stigma reduction, suicide prevention, student mental health, sustainability planning, and the Each Mind Matters, Walk in Our Shoes, and Know the Signs campaigns. She emphasized that at this point in the Evaluation Framework the CalMHSA is moving into the third box, which is to look at short-term outcomes. She noted that the goal is to see how suicide, discrimination,

social isolation, and student failure and disengagement can be reduced. She stated the Evaluation Summary will be ready by January 1, 2015.

Ms. Bauman announced the 7<sup>th</sup> International “Together Against Stigma” Conference to be held in San Francisco on February 17-20, 2015, and stated the hope that the Commission will participate in the conference.

**Commissioner Questions and Discussion:**

Chair Van Horn asked if the evaluation will need to be extended if the total expenditures are extended to 2018.

Ms. Bauman stated the evaluation effort would be reduced as the programs reduce.

Ms. Bauman, along with Ann Collentine, the Program Director of CalMHSA, at the request of Vice Chair Pating, provided an overview of the statewide projects and how they connect to CalMHSA.

Vice Chair Pating asked where CalMHSA is in the funding cycle.

Ms. Collentine stated the three-year funding ended in June 2014. It was decided to continue the existing projects for one year. Phase 1 was able to use dollars that had not yet been spent, so staff went through what was not used program by program to see what could roll forward. The no-cost extension allowed the roll-out of the rest of the programs on a reduced level. Phase 1 will end in June 2015. A 35-member constituency is working on Phase 2, which will begin in July 2015 and continue for two years at a proposed \$20 million per year.

Commissioner Poaster asked when the final RAND report is due.

Ms. Collentine stated a summary report is expected in January 2015, which will be available at both the CalMHSA and RAND websites.

**ACTION**

**13A: Approval Contract with Statistical Analysis System (SAS) Institute, Inc.**

**Presenter:**

**Renay Bradley, Ph.D., MHSOAC Director of Research and Evaluation**

Dr. Bradley gave an overview of the background, purpose, and selection process of the service contract to provide data hosting, analytics, training, technical assistance, and support.

**Commissioner Questions and Discussion:**

Commissioner Aslami-Tamplen asked if the Commission will have the ability to access county data and individual client data.

Dr. Bradley stated it will allow the Commission to better evaluate and assess county data. The Commission previously used external contractors to evaluate that data because of the lack of infrastructure to allow the Commission to do so internally.

Commissioner Nelson asked if the Commission will gain enough knowledge over the three years to bring it in-house or if it will continue to cost \$300,000 annually.

Dr. Bradley stated she did not know if the necessary improvements could be made to the Commission’s server room to make it secure enough. She anticipated that, after the use of the Statistical Analysis System (SAS) Institute services for three years, the Commission would assess the need for alternative solutions.

Commissioner Gordon stated this would provide a database capability with the required shields and safeguards around the privacy of personal data.

Dr. Bradley agreed. Staff would require training to learn how to securely access the data and the Commission would require a place to store it.

Dr. Bradley stated, in response to Commissioner Gordon's question, staff did explore the possibility of hosting the server somewhere other than in the Commission offices.

**Public Comment:**

Dr. Benhamida asked if this was a bidded contract.

Dr. Bradley stated staff looked at three alternatives. It was not put out to bid because it is a service contract.

Dr. Benhamida stated the concern that the Health Insurance Portability and Accountability Act (HIPAA) information will be collected.

Chair Van Horn stated the MHA-LA collected HIPAA information for several years at the personal level from the thirty-two counties that were Assembly Bill (AB) 2034 programs. It was a business arrangement with those counties, so it was HIPAA compliant. There are ways that allow the collection of individual data as long as proper protocols are observed to protect people. That is one of the reasons for this contract - to ensure Commission staff meets the required standard on all the necessary protocols.

Action: Commissioner Miller-Cole made a motion, seconded by Commissioner Nelson, that:  
*Authorize the MHSOAC Interim Executive Director to enter into a contract with SAS Institute, Inc. for an amount not to exceed \$900,000 over three years to provide data hosting services, analytic software, training, technical assistance, and support that will allow MHSOAC staff to access data and conduct research and evaluations internally.*

Motion carried, 10-0

**INFORMATIONAL**

**14A: Measurements, Outcomes, and Quality Assessment (MOQA) Data Report**

**Presenters:**

**Debbie Innes-Gomberg, Ph.D., District Chief, Los Angeles County Department of Mental Health (LA DMH)**

**Adrienne Shilton, Senior Associate, California Institute for Behavioral Health Solutions (CIBHS)**

Adrienne Shilton, the Senior Associate of the CIBHS, provided an overview of the MOQA Data Report, which is an initiative of the County Behavioral Health Directors Association (CBHDA) to demonstrate the statewide impact of public behavioral health programs. She stated the three primary drivers of this project were an increased recognition that counties were flooded with data requests; the call for outcomes from the Legislature; and the recognition at the leadership level of CBHDA that outcomes needed to be addressed.

Ms. Shilton gave an overview of the next phase of the MOQA project, MOQA-2, and asked the Commission for feedback on the draft categories in terms of how to seek outcomes across the system.

Debbie Innes-Gomberg, Ph.D., the District Chief of the Los Angeles (LA) Department of Mental Health (DMH) provided an overview of the county behavioral health outcomes, outcome domain details, and the next steps. She clarified that MOQA-1 was data that was commonly collected by counties, and that MOQA-2 takes it a step further and pushes counties to collect outcomes across all of their services. This has great potential to bring counties together in a way that will support all of the statewide organizations.

Commissioner Gordon stated the information on grades cannot be gathered through the school districts because grades are a confidential item in school district records. They are only disclosed if the child is involved in juvenile justice or the foster care system. The same applies to disciplinary actions.

Chair Van Horn clarified the meaning of the acronyms IMD (Institution for Mental Disease), SNF (Skilled Nursing Facilities), and MHRC (Mental Health Rehabilitation Center).

Commissioner Nelson asked if emotional and physical well-being is self-reported or if it is something the clinician would grade.

Dr. Innes-Gomberg stated it depends on the measure. Some are clinician-completed and others are client-completed.

Commissioner Nelson asked where a client can respond if a program in the county mental health system is not meeting their needs, such as low-recovery individuals who are in FSPs that either do not succeed or who graduate without reaching their goals.

Dr. Innes-Gomberg stated there are questions that address that in the Consumer Satisfaction Survey.

Chair Van Horn stated the MOQA Data Report gives Senator Steinberg what he has requested for eight years. Chair Van Horn listed the activities of the Commission that will enable a new data system to be put in place so that data can be put out statewide and can get down to the community level.

- The SAS contract
- The feasibility study

Chair Van Horn thanked Dr. Innes-Gomberg, Ms. Shilton, and the CBHDA for their work.

Commissioner Nelson asked if MOQA-3 will include stakeholders' input on the domain categories.

Dr. Innes-Gomberg agreed that the best practice in selecting measures is to include the consumers and family members who will use and be involved with the measures. It is essential.

## **ACTION**

### **15A: Adopt the Proposed Fair Political Practices Commission (FPPC) Standard Conflict of Interest Code**

**Presenter:**

**Filomena Yeroshek, MHSOAC Chief Counsel**

Filomena Yeroshek, the MHSOAC Chief Counsel, provided an overview of the background, the proposed amendments, and the process and timeline for adopting the proposed amended Conflict of Interest Code.

Action: Commissioner Buck made a motion, seconded by Commissioner Keith, that:

*The Commission approves the proposed amended Conflict of Interest Code for the Mental Health Services Oversight and Accountability Commission and authorizes the Executive Director to take the necessary steps to begin the rulemaking process and to submit the approved code with the supporting documentation as required by law.*

Motion carried, 8-0

## GENERAL PUBLIC COMMENT

Betty Dahlquist, the Executive Director of the California Association of Social Rehabilitation Agencies (CASRA), stated Senator Steinberg, as part of the Investment in Mental Health Wellness Act of 2013, funded the development of up to 2,000 crisis residential beds to serve as alternatives to hospital-based acute care. She stated a problem with implementation has occurred: the state has interpreted the law that the county must be the owner of any facilities funded under this section, or, if they are going to use a community-based-organization entity, that entity must agree to a 40-year lease. Ms. Dahlquist stated the decision was made as part of the regulations that the California Health Facilities Financing Authority (CHFFA) developed for Senate Bill (SB) 82.

Ms. Dahlquist asked the Commission to join the CASRA and other organizations in seeking a meeting with Secretary Dooley or someone else at a level to revisit this part of the regulatory package.

Chair Van Horn asked Ms. Dahlquist to compose a memo of exactly what she would like the Commission to do. The Commission can ask the CHFFA to attend a future meeting to explain why they chose to do it this way. Then, the Commission can consider whether it is necessary to seek a meeting with the new Pro Tem or the new Speaker of the Assembly to put in a correction bill to fix this.

Erin Reynoso, the Associate Director of the REMHDCO, stated her disappointment that there was no opportunity for public comment after the MOQA presentation, because she would have liked the counties to hear her comments. She stated she was excited about the MOQA presentation and commended them for what they are doing. She requested that counties consider adding a domain to measure the reduction of disparities in racial, ethnic, and underserved communities, or, if that is not possible, to consider collecting racial and ethnic demographic information in current domains.

Chair Van Horn asked Ms. Reynoso to draft a letter with her concerns and recommendations to Dr. Innes-Gomberg and Ms. Shilton.

Ms. Hiramoto supported Drs. Cheng and Benhamida's comments about a task force to determine the right disaggregation. At the community forum in Ventura, the League of United Latin American Communities (LULAC) presented a detailed report on problems in Ventura County serving the Latino community. She asked the Commission to address that report or to invite the LULAC to present at a future Commission meeting.

Ms. Hiramoto echoed Ms. Reynoso's concern about the lack of public comment after the MOQA presentation. She stated her hope that the MOQA representatives are consulting with the Commission, the DHCS, and the community and that the crisis residential program is serving ethnic communities.

Dr. Benhamida stated she was unsure of the racial, ethnic, cultural, and linguistic categories used in the MOQA report, and asked if reducing mental health disparities, life expectancy, disparities of accessing services, and provision of culturally- and linguistically-appropriate services will be measured. She stated the risk factors in the MOQA report seem to focus on consumer behavior, not the self-perceived risk from the political and social environment.

Mr. LaFollette stated discussing ways to reduce disparities is critical, but he cautioned against losing humanity in the discussions. Personal stories illustrate whether disparities are being reduced according to the intent of the MHSA. People in lofty positions often assume they know the best assessment method, use of funds, or way to fix the problem of disparities, when it is a far more complicated issue historically, emotionally, and ethically. He thanked the

Commission for the recent forum in Ventura. It was professionally done and everyone enjoyed it.

**ADJOURN**

There being no further business, the meeting was adjourned at 3:40 p.m.