



State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
January 23, 2014

Holiday Inn Sacramento - Capitol Plaza
300 J Street
Sacramento, California 95814

866-817-6550; Code 3190377

Members Participating

Richard Van Horn, Chair
David Pating, M.D., Vice Chair
John Boyd, Psy.D.
Sheriff William Brown
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.
Tina Wooton

Members Absent

Senator Lou Correa
Assemblymember Bonnie Lowenthal
Khatera Aslami-Tamplen
LeeAnne Mallel

Staff Present

Andrea Jackson, Executive Director
Kevin Hoffman, Deputy Executive Director
Filomena Yeroshek, Chief Counsel
Renay Bradley, Ph.D., Research and Evaluation Director
Deborah Lee, Ph.D., Consulting Psychologist
Dee Lemonds, Staff Mental Health Specialist
Jose Oseguera, Committee Operations Chief
Norma Pate, Administrative Chief
Lauren Quintero, Associate Government Program Analyst
Kristal Carter, Staff Services Analyst
Cody Scott, Office Technician

1. CALL TO ORDER/ROLL CALL

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:37 a.m. and welcomed everyone. Administrative Chief Norma Pate called the roll and announced a quorum was present.

2. INTRODUCTION OF MHSOAC EXECUTIVE DIRECTOR ANDREA JACKSON

Chair Van Horn introduced new MHSOAC Executive Director Andrea Jackson. He stated she was Senate President Pro Tem Darrell Steinberg's Chief of Staff and the principal staff member in drafting Proposition 63 (Prop 63). He welcomed Executive Director Jackson to the Commission and stated he looked forward to working with her.

3. APPROVE THE NOVEMBER 21, 2013, MHSOAC MEETING MINUTES (ACTION) JANUARY – MARCH 2014 MHSOAC CALENDAR JANUARY 2014 MHSOAC EVALUATION DELIVERABLES DASHBOARD PLAN UPDATE REVIEW DASHBOARD 2013 WORK PLAN ACCOMPLISHMENTS

Vice Chair Pating asked that the number of psychiatrists be changed from nine to 99 on page 41.

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

MHSOAC approves the November 21, 2013, MHSOAC Meeting Minutes as amended.

- Motion carried, 12-0

4. OVERVIEW OF GOVERNOR'S PROPOSED BUDGET FOR FY 2014-15

Kiyomi Burchill, the Assistant Secretary of the California Health and Human Services Agency (CHHS), provided an overview of the governor's proposed budget for fiscal year (FY) 2014-15 as it relates to community mental health. The FY 2013-14 budget completed the state administrative integration of mental health with substance use disorders and physical health within the Department of Health Care Services (DHCS) to improve the coordination of care and to ensure that mental health and substance use are considered a part of broader health care initiatives.

Three Key Initiatives

Ms. Burchill summarized three key initiatives in the governor's budget related to health care and community mental health that were enacted as a part of the FY 2013-14 budget: Health Care Reform, expanded mental health benefits within the Medi-Cal program, and the Investment in Mental Health Wellness Act of 2013.

Health Care Reform. California is in the midst of implementing federal Health Care Reform, which will extend coverage to millions of Californians. As of this month, Californians have access to affordable, quality health insurance through Covered California, the health insurance marketplace. By law, health insurance plans cannot deny coverage due to preexisting conditions. The state Medicaid program, Medi-Cal, was also expanded to include individuals at 138 percent of the federal poverty level and below.

Over 500,000 individuals have enrolled in coverage through Covered California, 584,000 applicants have been found to be likely eligible for Medi-Cal, and 630,000 individuals have transitioned into the Medi-Cal program from California's low-income

health program. By FY 2015-16, 1.9 million people are anticipated to have coverage through Covered California, and 1.4 million people are anticipated to have coverage through the Medi-Cal program.

Expanded Mental Health Benefits within the Medi-Cal Program. There are expanded mental health benefits for individuals already in Medi-Cal or who are coming into Medi-Cal through the coverage expansion. Specialty mental health services continue to be delivered by county mental health plans, but, as of this month, there are expanded benefits delivered by Medi-Cal managed care plans. For Medi-Cal beneficiaries not enrolled in a managed care plan, the expanded benefits are delivered through the fee-for-service system.

The expanded benefits focus on low-level diagnoses: individual and group mental health evaluation and treatment, psychological testing when clinically indicated to evaluate mental health condition, outpatient services for the purposes of monitoring medical treatment, outpatient laboratory, medication supplies and supplements, and psychiatric consultation.

Investment in Mental Health Wellness Act of 2013. The Investment in Mental Health Wellness Act of 2013 provided \$206.2 million to strengthen local capacity to better stabilize and treat patients with mental illness. It consists of three components:

1. The California Health Facilities Financing Authority (CHFFA) is tasked with providing grants to counties to add twenty-five mobile crisis support teams in the state, an additional 2,000 beds in crisis residential treatment programs, and additional crisis stabilization units. CHFFA is reviewing applications submitted by counties and will make awards.
2. MHSAAC is tasked with providing grants to add 600 triage personnel.
3. The Office of Statewide Health Planning and Development (OSHPD) received \$2 million for training for mental health peers. Contracts will be awarded to organizations that develop career pathways and training that lead to employment by peers within the community mental health system.

Carla Castañeda, the Principal Program Budget Analyst of the California Department of Finance (DOF), stated the mental health services fund revenues in the governor's budget increased from the May Revision estimates for FYs 2012-13 and 2013-14. For the past year, the revenue is expected to increase by about \$50 million for a total of \$1.477 billion. In FY 2013-14, the increase was about \$240 million for a total of \$1.375 billion. The forecast for 2014-15 revenues is \$1.587 billion.

In addition to establishing the Investment in the Mental Health Wellness Act of 2013, Senate Bill (SB) 82 also restored the five percent administrative cap. The 3.5 percent administrative cap was approximately \$40 million. The five percent administrative cap for 2013-14 is \$68.8 million.

The current expenditures of the governor's budget were \$80.3 million, which exceeds the cap by \$11.5 million, but assumes the full budgeted amount for all three Mental Health Services Act (MHSA or the Act) funded grants.

Commissioner Questions and Discussion:

Chair Van Horn asked what will be left within the cap after the five-month funding of the triage grants and the four-month funding of CHFFA grants.

Ms. Castañeda stated, since the award proposals for the other two grants are still pending, there would be approximately \$11.5 million at the recommended staff level.

Vice Chair Pating asked where the money resides.

Ms. Castañeda stated the state controller continues to account for all of the funds. On a monthly basis, the state allocates any unreserved amounts to the counties. Presently, the full grant amounts are reserved as budgeted, pending the final recommendations from the three departments. The funds remain in MHSA fund.

Commissioner Poaster asked if the new estimates of the fund amount allows for more funds for the triage component than was initially thought.

Ms. Castañeda stated there is a little room in the current year, based on staff recommendation. Going forward, the cap for 2014-15 is estimated at \$79.4 million, with the proposed expenditures of the full grant amounts at \$80.7 million or about \$1.3 million over, which will be revised in the May Revision for the new revenues.

Commissioner Poaster stated that would only be available for FY 2013-14.

Ms. Castañeda stated the current recommendations would almost allocate the \$32 million.

Commissioner Buck asked if county mental health programs can expect to receive a mid-year increase in community services and supports (CSS) funding.

Ms. Castañeda stated the amount of revenues that were allocated to counties for their three-year plans was \$1.6 billion for FY 2012-13. The forecast for FY 2013-14, which is still in process as there are several months of revenues yet to allocate, is \$1.3 billion. Anything that is not already reserved through the Budget Act is allocated on a monthly basis. In the current year, it is a monthly receipt, and, going forward, it will be an annual adjustment.

Commissioner Poaster stated, in terms of the money distributed for the components of the Act, the money goes out as it comes in. If there is more money coming in than anticipated, there would be more money going out. The triage component uses administrative dollars, which are capped at five percent of gross revenues, and will also increase.

Ms. Burchill added that the revenue projections are done in January and May. She offered to report to the Commission on the May projections, as they are more accurate.

Commissioner Nelson asked who would be responsible for peer certification.

Ms. Burchill stated that is beyond the scope of the \$2 million that OSHPD received, but OSHPD is in active dialogue with other agencies regarding peer certification.

Commissioner Nelson stated the dialogue has gone on long enough. It needs to be determined what department will be responsible for peer certification.

Chair Van Horn stated the workforce, education, and training (WET) dollars are under the purview of the California Mental Health Planning Council (CMHPC). A peer certification program is important because training is uneven around the state.

Commissioner Boyd acknowledged the work of the state departments, the governor, and the Legislature for sending a clear, strong message about mental health services. This is the first time in California that there has been such a demonstrated commitment to this work. He asked that the Commission find a way to formally acknowledge and recognize these efforts.

5. REVIEW AND ADOPT 2014 MHSA FINANCIAL REPORT (ACTION)

Kevin Hoffman, MHSOAC Deputy Executive Director, stated the Financial Oversight Committee prepares a report twice a year based on information from DOF and other sources.

Mr. Hoffman stated the revenue projections for FY 2014-15 have gone up. Realignment I and II and federal financial participation are the major funding sources in this projection. The revenue for MHSA funding is susceptible to economic fluctuations, but a significant increase is projected for FY 2014-15.

The state controller's office distributes funds on a monthly basis directly to the counties from the Mental Health Services Fund. To date, \$400.4 million have been distributed to the counties.

Mr. Hoffman stated there are still approximately \$79 million in uncommitted MHSA funds for MHSA Housing Program. \$321.2 million in MHSA funds have been committed to date for a total of \$2.78 billion in development costs from all funding sources.

Commissioner Poaster noted that the leveraging effort is about eight to one. Every MHSA dollar that is put into housing generates another eight dollars in other resources. Housing developers can generate additional funds outside of the initial seed money, and MHSA provided the first dollars to many projects, which have multiplied to almost \$3 million from MHSA's initial \$400,000.

Mr. Hoffman showed a slide of the State Administered Funds for FY 2012-13 broken up by state department with a total of \$80,695. He noted that, although the number looks large for MHSOAC, \$32 million of the budgeted \$40,948 is for the triage funding.

Vice Chair Pating recommended displaying the triage funding as a separate line item to better depict MHSOAC's actual overhead.

Action: Commissioner Poaster made a motion that:

MHSOAC accepts the January 2014 Financial Report as presented by MHSOAC Financial Oversight Committee.

- Motion carried, 12-0

6. REVIEW AND APPROVE COUNTY TRIAGE GRANT PROPOSALS (ACTION)

Mr. Hoffman stated SB 82, the Investment in Mental Health Wellness Act of 2013, authorized CHFFA and MHSOAC to administer two competitive selection processes for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization, crisis residential, and specified triage personnel.

CHFFA is responsible for adding at least twenty-five mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential beds. MHSOAC is responsible for adding mental health triage personnel statewide through a competitive grant process. \$32 million in MHSA funds is available annually for mental health triage personnel grants.

On September 26, 2013, the Commission approved the criteria for a Request for Application (RFA) for mental health triage personnel. The Commission also approved dividing the \$32 million available annually between five established regions identified by the California Mental Health Directors Association (CMHDA). Counties competed within their regions for grant funding. Counties were given until January 3, 2014, to submit grant applications. Counties were asked to provide the following: a program narrative consisting of a description of their current crisis response system, how they would use triage personnel to fill system gaps, their collaboration efforts, and how the county would operationalize triage services; a budget request; and a description of required reporting and evaluation processes.

The Commission received forty-seven triage grant applications. The applications then went through a reviewing and scoring process.

Mr. Hoffman recommended fully funding the twenty-two highest scoring applications with available funds in each region, and combining surplus funding in each region to fully fund the county with the next overall highest scoring application that could not be funded due to the unavailability of funds in that county's region. These recommendations will result in funding twenty-two counties.

All programs will collect and report information to MHSOAC about the number of persons served, the type of services they receive, service referrals, whether persons served successfully accessed services, and whether persons served were enrolled in mental health services at the time of the crisis intervention. All programs will document the effectiveness of their expanded crisis services and will track individual and system outcomes.

Commissioner Questions:

Commissioner Boyd asked in relation to the context for unexpended funds, what those numbers are and what causes them to fall into that category.

Mr. Hoffman stated the numbers reflect the remaining funds after funding all proposals with the available funding.

Commissioner Boyd asked why the unexpended funds for FY 2013-14 were over \$19 million.

Mr. Hoffman stated the funds are being implemented late in the year. Staff derived the figures based on the assumption that the \$32 million was available. The figure is incorrect because tax revenues are lower.

Commissioner Poaster stated his concern over losing the \$19 million.

Commissioner Boyd agreed and stated it needs to be complemented by some of the other questions related to full-time equivalents (FTEs) and the counties' use.

Ms. Castañeda responded that the governor's budget estimates the revenue at the \$32 million level, over the cap by \$11.5 million. Of the \$19 million that is unused in these grants, \$11.5 million would be subtracted, which would still leave approximately \$7 million within the cap.

Commissioner Boyd asked for the analysis on FTEs and costs by county, and the criteria used for peer engagement programs. There are counties with 2.5 FTEs that plan to take 0.5 of that to ensure they have a peer represented. He asked why larger counties with much larger requests that have no peer engagement programs are scored at a high level.

Mr. Hoffman stated the Request for Application (RFA) did not direct counties to employ certain numbers of clinicians. The RFA asked for counties to provide information on their needs. Staff relied on the counties to clarify the classifications needed to fulfill their proposal.

Commissioner Boyd stated, allowing for demographic disparities, the cost index should be more closely aligned between the counties, and he was still concerned about the cost explanation and the level of analysis given. He wanted to ensure that the use of the funds is efficient and well-explained and that the right mechanisms are in place. He asked if counties' acceptance of peers was a factor in the review process. Even if it was not a formal part of the submittal, this Commission feels strongly about peer engagement and peer support. He stated his disappointment that some counties were not more aggressive in peer engagement and support programs.

Dee Lemonds, an MHSOAC Staff Mental Health Specialist, addressed the analysis of the cost and the variants. Staff considered the budget sheets, the wide variance in the types of classifications being used, and the differences in cost between county staff and contract staff that frequently exist. There is also a variance in salary and benefits. Staff did not judge counties on specific costs, but whether the costs were reasonable and feasible.

She stated she was happy to see 184 peer positions included in the applications. Counties were marked down in the section where they described what the staff would do if peers were not included. Counties could still score high enough for funding even though they were marked down in this area.

Commissioner Boyd stated it is important to note that 100 of the 184 peer positions are in Los Angeles County. This is a reminder to the other counties that this is a direction the Commission is going and is looking for in terms of funding.

Chair Van Horn stated 600 triage positions were anticipated in SB 82.

Commissioner Carrion stated his concern for counties that did not receive funding. He asked if there were certain themes in the counties that scored high in the review process. He suggested that staff identify strong programs that may not be good in terms of design, but may be good in terms of implementation. He asked if there are funds for a second process of identifying different models and bringing those to counties that demonstrate a need.

Commissioner Miller-Cole asked staff to provide examples of the poor-scoring counties.

Commissioner Gordon stated Nevada County is scheduled for almost \$2.5 million. Placer County is five times the size and they are getting the same funding, and Calaveras County is about half the size and they are getting one-tenth the funding.

Ms. Lemonds stated the counties were instructed to ask for what they need.

Commissioner Gordon asked if there were grants to counties which are collaborating. It seems there is a disproportionate funding if they are only serving their own population.

Ms. Lemonds stated staff was surprised there were no joint county proposals.

Mr. Hoffman stated the Commission was mandated to build a competitive process. Staff put out an RFA requesting counties to send their proposal to the Commission based on their needs.

Commissioner Poaster asked if there is a way to avoid having FY 2013-14 funds swept at the end of the year.

Ms. Castañeda stated DOF will report their encumbered funds at the end of the year. If the Commission chooses to continue to monitor the funding for this year, they can continue to encumber and review it. The revenues will change and the cap will change based on the revenues. The funding will remain available in the fund until DOF has submitted the claim to the controller.

Chair Van Horn clarified that MHSAAC is to tell DOF that the funds will not be used. He asked when the Commission needs to tell DOF.

Ms. Castañeda stated DOF looks at every year that has an open authority every summer. When departments close out their accounting documents in July, they report to DOF in August about how much they expect to encumber.

Chair Van Horn stated the counties are encouraged to keep reserve funds. Counties can sequester unspent funds for up to three years.

Ms. Castañeda stated, if there is funding still available in the budget authority and reviews are still being done, those dollars can remain an open item for the Commission.

Commissioner Poaster asked if the Commission can encumber the funds for the three years to get it out of the state budget and out to the counties for the purpose of the Investment in Mental Health Wellness Act of 2013.

Ms. Castañeda stated the Commission was given authority in SB 82 to make the 600 triage personnel competitive grant. That mechanism and this proposal are the result of the stakeholder process. If there was another proposal for the remainder, the Commission, through SB 82, has authority to decide how that competitive process for triage personnel grants should work. If the Commission does something else with the

remainder to develop a process to allocate these funds, then the department will notify DOF that the funds are encumbered and will be spent over the course of two years and five months.

Commissioner Poaster asked the executive director and staff to immediately explore options so that the Commission can build on today's progress.

Vice Chair Pating stated his concern over accepting the results of the RFA, and questioned if something was missed in the planning that has resulted in not meeting some of the intent language of the bill. He also stated his concern over the distribution of the funds. He questioned whether this is meeting statewide needs when so much of the state is not receiving these funds. He asked how this lines up with CHFFA projects that might be in those areas. While the process was visibly fair, the distribution of funds may not be. The well-staffed, well-to-do counties received more funds than those counties that may have the greatest needs due to perpetual underfunding. There is an unintended consequence where monies are going to high-density areas, while low-density areas have large needs that are still unmet.

Mr. Hoffman stated the distribution of funds was based on a mandated competitive process. If it was just a grant process, the funds would have been distributed to all counties based on a formula. In a competitive process, counties submitted what their needs were and staff scored based on the validity of the proposal. Also, the author's intent was that CHFFA and triage programs were not to be tied. They could be somewhat linked, but the triage staff were not to staff CHFFA residential treatment programs. They were to be separate proposals.

Vice Chair Pating stated the rules given for the Commission's oversight role of creating a rational mental health system includes not accepting results that, on a fundamental distribution, do not make sense. He asked, while abiding by the mandated process and in light of the questionable results, whether there are alternative options to consider.

Commissioner Nelson asked about the red ink on the Bay Area of \$1.2 million more than that area was allotted.

Mr. Hoffman stated the red ink for the Bay Area goes back to the recommendations for funding distribution. Staff recommends funding Alameda County with the surplus funds, but at this point, they were not funded because they exceeded the cap. Alameda County would be the next highest scoring county to receive funds.

Executive Director Jackson stated Motion 3 is included to address the concern over distribution. The \$19 million could potentially go to these counties. It was required by the legislation to do it in a competitive way, and it was the intent of the author to do it that way. It could not be done on a formula, but Motion 3 gives the Commission some latitude to help the counties that may not have the resources to make a good RFP with those additional monies the Commission intends to encumber.

Public Comment:

Helena Liber, of the Client Stakeholder Project, speaking as a consumer, stated she is concerned about the place of consumers in the new peer specialist certification. She requested it be defined and explained within proposals and programs that peers should include both family members and consumers. She suggested it be a fifty-fifty

designation of family members or consumers. She stated her concern that consumers will be lost within the peer designation now that it includes both family members and consumers.

Silly Zinman, the Program Director of the Client Stakeholder Project and the Executive Director of the California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated she was pleased to hear the questions about the number of peers involved in the program. The Investment in Mental Health Wellness Act of 2013 was based on using peers in many of the positions in crisis response vehicles and suggests peers be used in the triage program. She stated her concern over funded counties that either did not include peers or only included minimal use of peers.

Steve Leoni, consumer and advocate, agreed with Commissioner Pating about unintended consequences. Many small counties do not have the resources to provide pro forma content and the data necessary to submit an application. Competitiveness should be on the inherent quality of the proposal and the starkness of the need filled. He suggested retooling the competitive process to include accommodation for counties that do not have the necessary resources, or providing technical assistance for small counties to submit a proposal.

Jim Gilmer, of the California MHSA Multi-Cultural Coalition (CMMC) and the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), urged the Commission to not only look at the peer perspective. This is a huge investment in serving disenfranchised, marginalized, hard-to-reach, and incarcerated people. With that in mind, some investment in engaging racial and ethnic cultural communities is important. It should be more holistic. He was disappointed in the disproportionate investment in a traditional methodology that does not incorporate the strategic plan, the California Reducing Disparities Project (CRDP), and research. He recommended leveling the playing field and revisiting a broader-based, inclusive strategy.

Adrienne Shilton, of CMHDA, stated her concern that the \$19 million will be lost. She agreed with finding a way to allocate these funds to the next highest-scoring counties. She requested an expedited release of individual score sheets for each of the counties, showing how they scored across the various criteria, so counties can review that. Chair Van Horn stated staff will make this available.

Commissioner Boyd stated all counties in California need these funds. He asked if CMHDA has an understanding of why all counties did not apply.

Ms. Shilton stated she did not know why thirteen counties did not apply. CMHDA plans to continue the discussion to ascertain the reasons.

Wayne Clark, the Board President of the California Mental Health Services Authority (CalMHSA), stated most of the counties submitted proposals not based on need, but on want. If counties got what they needed, it would be a more comprehensive statewide approach. If the Commission looked at what each county needed and allocated accordingly, there would be a better outcome. He suggested respecting the intent of the legislation so that it would be competitive, respect the scoring, then take those percentages the counties scored and use that to allocate to all the counties that applied, assuming they have a need.

Based on need, all counties that submitted proposals would be awarded about 70 percent of what they asked for. One of the ways to do it for this year is to do three-twelfths instead of five-twelfths, giving the counties two months to hire personnel and contractors. Allocating 70 percent across all counties that applied would satisfy the need. This would give a much broader statewide way of respecting the legislation, the intent, and the process of scoring, and then giving services statewide.

Commissioner Carrion stated he liked the suggestion. He asked how to protect against spreading the funding so thin that no program becomes effective.

Dr. Clark suggested that staff work with counties to allocate only what is needed.

Ms. Shilton stated CMHDA had two representatives on the subject matter expert panel, were part of the process, and did negotiate with stakeholders.

Commissioner Discussion:

Commissioner Poaster stated he echoed Commissioner Boyd's concerns. Also, CHFFA grants are different than triage, but will gain the same outcomes. CHFFA grants are one-time money, whereas the triage personnel grants are on-going money. He asked what counties submitted to CHFFA grants and what they submitted to the triage grants, and stated his concern over the impact on CHFFA grants for counties that were not approved for the triage personnel grants.

Chair Van Horn agreed that there was an error in this legislation of assigning this to two different groups and making them operate independently.

Commissioner Poaster stated, although he did not agree with the competitive process, counties that spent time thinking about it should not be penalized over counties that may not have spent as much time. He noted many small counties are being funded, indicating that they put a lot of thought into their proposals. He was uncomfortable with making a decision until he knew the issues, such as the relationship with CHFFA grants.

Chair Van Horn noted that CHFFA grants were due yesterday. Staff contacted CHFFA and Chair Van Horn announced that CHFFA received thirty-three applications. Thirteen counties also submitted applications for CHFFA grants that were funded for the triage personnel grants.

Mr. Hoffman stated staff has met biweekly with CHFFA for the past six months to ensure they were in agreement moving forward.

Commissioner Boyd stated he will not lose sight of the counties that did not apply. He asked staff to provide a list of those counties. This was a timely legislative move. Counties need services now. There is a surplus of about \$7 million in the FY 2013-14 funding year. The question is not about the funding of the next six to eight months, but of the subsequent years.

He used the example of funding all counties, but asking that 50 percent of their staff positions be peer-based. That would impact, just on the approved counties alone, approximately 60 FTEs. A 50 percent staffing model represents a significant dollar opportunity that could help subsidize the funding in subsequent years. He stated, for 60 FTEs of licensed staff, he could pay for about 110 peers. He stated withholding these

dollars would be a mistake. He represents many counties as a provider and sees firsthand every day how these kinds of services would impact public health.

Chair Van Horn stated dividing the \$32 million by the \$5 billion mental health system is six-tenths of one percent. Looking at the whole picture, this is a small amount. The question is whether some counties are being treated unfairly due to a process that the Commission approved and engineered, and whether the Commission is short-changing its commitment to peer involvement by allowing so many counties to have entirely licensed personnel. If peers are not identified in a county's proposal, the Commission has no knowledge of the county's employment of peers or of the peer employment practices of the contract community agencies that county deals with.

Chair Van Horn agreed with Commissioner Boyd that programs are needed now, and a way to understand what specialty triage can bring to the overall system as models and pilots for the future. The triage approach is something that is relatively new to the mental health world, which has historically been forced to serve fewer people than need services. The Commission needs to sort out the fairest thing for the counties that did apply and did score well.

Commissioner Gordon stated the competitive process has been completed, and to reset the terms to ask for additional peers when it was not requested in the first place is unfair. The larger issue is ensuring a statewide system is in place in all counties. The counties that did not apply have needs as well. He suggested a way to address this is to get the counties to cooperate more and share resources regionally. The mission should be to ensure it is a well-functioning system everywhere, and to learn from the good points of the counties that were successful in the competition.

Chair Van Horn agreed that several counties have set the bar very high with peer employment, and they will be an example to counties that did not apply. This pilot set of programs is the first intense effort to get anything about triage across the board that will create a system that understands triage.

Commissioner Brown stated the underlying problem with this and most grant processes is a greater need than there are available resources. There is a probability that many of the counties that did not apply did not have the resources to apply. However flawed the process may be perceived retrospectively, it would not be advisable or fair for the Commission to change the rules after the game has been played. There was a competitive process. The counties submitted proposals on the same playing field, and the Commission should approve what has been done. He suggested, in addition to limits on regional amounts, that there also be caps by size of county in terms of awards, which may make more awards available in the future. He suggested the Commission make a recommendation to the Legislature if it is perceived that this process had an unintended consequence.

Commissioner Nelson agreed with Commissioner Brown that it was a mistake to not limit counties to only what they need. Some counties may have gotten a disproportionate amount of the money that was allotted to that region.

Commissioner Wooton stated her hope that the Commission will talk more about the value of peers in the workplace and spread that information statewide so more counties will understand that value.

Chair Van Horn named the thirteen counties that did not apply.

Commissioner Carrion noted they were all counties where the Commission has not yet held community forums.

Chair Van Horn agreed, but stated community forums have been held in adjacent counties.

Commissioner Nelson assured that community forums will be there this year.

Commissioner Carrion stated his concern that there are no funds for the evaluation process of the triage programs across the state as a Commission. Not knowing if something that works in one county will work in another county is another potential problem for the future.

Executive Director Jackson stated staff will discuss the potential of allocating funds for the evaluation process with legislative staff.

Mr. Hoffman stated Dr. Bradley will be helping with the evaluation of the information staff requested through the RFA.

Commissioner Carrion stated the counties have their own way of assessing what they are doing, and they will report their accomplishments to the Commission. He asked if there was something in place for the Commission to objectively evaluate every program across the state.

Renay Bradley, Ph.D., MHSOAC Research and Evaluation Director, stated the tracking and monitoring evaluation requirements are extremely basic. They enable staff to understand whether or not the basic goals of the Act are being achieved. This can be done at the statewide level because all grantees are required to submit that information in their reports. Per the RFA, all grantees have designed their own evaluation efforts that would show the outcomes and enable staff to tell whether or not the program achieved the goals on an individual level.

Commissioner Carrion asked if the Commission will be in a position to evaluate what components of what programs are most effective.

Dr. Bradley stated the state will not, but the counties will evaluate with the funds allocated to them. The components of evaluation were included in the counties' grant proposals.

Chair Van Horn agreed with Commissioner Gordon's approach. He noted there was not one collaborative proposal. He asked why some small counties did not collaborate with other small, neighboring counties to submit joint applications.

Vice Chair Pating asked if there can be more flexibility in how the remaining funds will be spent. Motion 3 funds the next highest overall score, but that may not resolve some of the issues.

Filomena Yeroshek, MHSOAC Chief Counsel, stated this is the first grant cycle. Staff legally put out an RFA, and all the rules were set out. Once it is a competitive process, changing the criteria for awarding funds is problematic. Motion 3 ties it to the overall highest scores. She suggested looking at the next grant cycle, FY 2017-18, where, hopefully, there will be more funds and lessons learned from this initial process. The

Commission can start several years ahead of time, unlike this time around where there were only a few months to prepare.

Commissioner Gordon suggested the Commission begin talking about countywide collaboration well in advance of putting out another grant request, and frame the idea of how to get from the initial group that was funded to the scale of a statewide system.

Chair Van Horn stated the next grant cycle proposals will be during FY 2016-17. He suggested the Commission begin talking about collaboration the year before that.

Chair Counsel Yeroshek stated the \$32 million in ongoing funds are legislatively limited for competitive grants. That can be changed; the law is never static. The elements of that competition can also be refined.

Commissioner Miller-Cole spoke in favor of the original motion with the three staff recommendations because it has gone through a fair and transparent process. He stated his concern over looking at this as an iterative process. He asked that the voice of workers be included in this process. If the goal is to develop and incentivize a rational mental health system in California, one of the key lenses is to look at the experiences of the workers providing these services, including peers, professionals, and paraprofessionals.

Chair Van Horn agreed that the Commission needs to look at the workers' experience in this. If the Commission pushes for another piece of legislation that would start another cycle to expand this out, there are things this Commission needs to take a hard look at, such as the next set of requirements and awards, and whether it is a competitive process or an allocation process with specific requirements and evaluative mechanisms.

Vice Chair Pating requested that the press release communicate Commissioner Gordon's, Commissioner Miller-Cole's, and Chair Van Horn's statements. The intent of the Commission is to continue to look in an iterative way to addressing the concerns of peers, workforce, and a viable rational mental health system.

Executive Director Jackson stated this legislation is reminiscent of Assembly Bill (AB) 34. It was assigned to the Commission with short notice and asked for quick results. If these pilot programs succeed, it may result in another Proposition 63. That is the way it happened then and the hope is that it is the way it will happen now.

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

1. MHSOAC awards triage personnel grants to the following counties for the specified amounts listed, inclusive of fiscal years 2013-14 through 2016-17, and directs staff to post in MHSOAC office lobby and on MHSOAC website, before the close of business on January 23, 2014, the Notice of Intent to make the following awards.

Ventura	\$7,573,673	Madera	1,380,596
Riverside	8,616,543	Merced	3,003,068
Santa Barbara	8,348,530	Sonoma	3,044,364
Orange	10,250,000	Napa	1,323,633
Los Angeles	31,177,000	San Francisco	14,365,128
Yolo	1,728,233	Marin	1,100,057
Calaveras	262,686	Alameda	2,666,830
Tuolumne	478,512	Butte	1,075,070
Sacramento	4,474,907	Lake	184,793
Mariposa	699,428	Trinity	497,713
Placer	2,509,346	Nevada	2,479,091

2. MHSAOAC authorizes the executive director to execute all necessary documents to distribute the grants awarded to the counties upon expiration of the protest period or consideration of protests, whichever comes first.

3. After fully funding the twenty-two counties, if there are remaining funds insufficient to fully fund the county with the next overall highest application score, the executive director is authorized to offer these “partial” program funds to that county. If that county declines the partial program funds, the executive director is authorized to offer the funds to the county with the next highest scoring application until an eligible county accepts the funds.

- Motion carried, 12-0

7. GENERAL PUBLIC COMMENT

Ms. Liber stated her concern that MHSA stipulates that the funds will not supplant existing programs. Some counties have existing programs and they lack the funding for them. They cancel those programs and set up new programs they can use MHSA funds for. On the statewide level, the state has done away with the mental health department. Now, MHSA is seen as the funding source for mental health programs. Mental health services are shrinking due to lack of funds, and MHSA funds are used to provide basic services.

Mr. Gilmer stated he was encouraged at the last MHSAOAC meeting when it was recommended that CRDP would be invited to have a roundtable dialogue. The terms “peer” and “family member” are not congruent in some communities. He stated the need for the Commission to hear from CRDP partners and other communities on what works best for them. Using the same terms and the same strategies perpetuates disparities. He looks forward to having that dialogue so all can learn to reduce disparities and truly serve California as MHSA originally intended.

Chair Van Horn stated the \$60 million CRDP is assigned to the California Department of Public Health (CDPH) and is not sustainable. He suggested Mr. Gilmer speak with the president of CalMHSA about their sustainability proposal.

Mr. Gilmer stated he was open to having that dialogue, but reducing racial and ethnic disparities is not just a short-term \$60 million project. It is universally applicable to all of

MHSA and should be imbedded in everything. CRDP has a wealth of knowledge and expertise they would like to share to help the system be more culturally congruent.

8. PRESENT AND ADOPT 2014 COMMITTEE CHARTERS

Client and Family Leadership Committee

Ralph Nelson, Chair; Tina Wooton, Vice Chair

Commissioner Nelson reviewed the purpose, objectives, guiding principles, and activities of the Committee's 2014 Charter. The Committee plans to utilize the Community Forum Workgroup to continue quarterly forms, expand and diversify the methods by which MHSOAC receives input from people with lived experience of mental illness, develop strategies for promotion of client and family employment, report findings of the Crisis Intervention Team Training survey, conduct the stakeholder orientation, create a work group to review methods to engage individuals who have not fully benefited from MHSA services, provide input on MHSOAC evaluation efforts, communicate lessons learned and best practices from evaluations, and work with DHCS to obtain updates on the development of MHSA issue resolution process.

The 2014 Community Forums will be held from 3:00 p.m. to 6:30 p.m.:

- February 20th, in Emeryville
- May 8th, in Shasta County
- August 7th, in Mammoth, Mono County
- November 6th, in Oxnard, Ventura County

Commissioner Nelson announced that by the end of this year the community forums will have been held in all counties with adjacent counties also invited to attend those forums.

Action: Commissioner Nelson made a motion, seconded by Commissioner Wooton, that:

MHSOAC adopts the 2014 Charter for MHSOAC Client and Family Leadership Committee.

- Motion carried, 12-0

Cultural and Linguistic Competence Committee

Victor Carrion M.D., Chair; Khatera Aslami and LeeAnne Mallel, Vice Chairs

Commissioner Carrion reviewed the purpose, objectives, guiding principles, and activities of the Committee's 2014 Charter. He stated cultural and linguistic competence issues should be addressed in every Committee and in every decision made. The Committee plans to continue the quarterly community forums, expand and diversify the methods by which MHSOAC receives input from people with lived experience of mental illness, review the CDPH's CRDP strategic plan, prepare an annual cultural competence presentation, communicate progress in reducing mental health disparities to build collaboration in access, quality, and services, monitor the statewide collection of disparity data, provide input on MHSOAC evaluation efforts, conduct an initial

organizational self-assessment of MHSOAC, and endorse and promote strategies that transform the mental health system.

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

MHSOAC adopts the 2014 Charter for MHSOAC Cultural and Linguistic Competence Committee.

- Motion carried, 12-0

Evaluation Committee

David Pating, Chair; Victor Carrion, Vice Chair

Vice Chair Pating reviewed the purpose, objectives, guiding principles, and activities of the Committee's 2014 Charter. The Committee plans to support MHSOAC Evaluation Master Plan, support the performance indicators in the Master Plan, support forthcoming efforts of the Master Plan, strengthen the data collection, communicate lessons learned, work with the other MHSOAC Committees, revise the policy paper, receive input and support clients and family members, seek integration in evaluation efforts, disseminate policy recommendations, and oversee the quality of the statewide Prevention and Early Intervention (PEI) projects to report back to the Commission.

Action: Vice Chair Pating made a motion, seconded by Commissioner Miller-Cole, that:

MHSOAC adopts the 2014 Charter for MHSOAC Evaluation Committee.

- Motion carried, 12-0

Financial Oversight Committee

Larry Poaster, Chair; John Boyd and John Buck, Vice Chairs

Commissioner Buck reviewed the purpose, objectives, guiding principles, and activities of the Committee's 2014 Charter. He stated the Committee is the monitoring and financial review Committee for the Commission. The Committee plans to produce semiannual financial reports, work with DOF on projections, review fiscal data and analyses for policy implications, monitor the status of CalMHSA expenditures, review DHCS supports for training and technical assistance, review and revise policies, receive reports regarding "roles and responsibility discussions" between entities who have shared financial oversight of MHSA funds, receive regular updates on evaluation efforts, and expand and diversify the methods by which MHSOAC receives input from people with lived experience of mental illness.

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

MHSOAC adopts the 2014 Charter for MHSOAC Financial Oversight Committee.

- Motion carried, 12-0

Services Committee

Christopher Miller-Cole, Chair; Bill Brown, David Gordon, and Tina Wooton, Vice Chairs
Commissioner Miller-Cole reviewed the purpose, objectives, guiding principles, and activities of the Committee's 2014 Charter. The Committee plans to develop a implementation plan for the Technical Assistance and Training (T/TA) policy paper, monitor the status of PEI and Innovation (INN) program and expenditure proposed regulations, promote strategies that transform the mental health system, support T/TA to disseminate successful INN programs, review MHSA program implementation trends, monitor Affordable Care Act (ACA) implementation, maximize behavioral health care, provide input on evaluation efforts, continue oversight of statewide PEI projects, diversify the methods by which MHSOAC Committees receive input from people with lived experience, and examine options to use evaluation results to demonstrate success and challenges of mental health programs.

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

MHSOAC adopts the 2014 Charter for MHSOAC Services Committee.

- Motion carried, 12-0

9. STATUS REPORT ON CALMHSA PROGRAM FUNDING, EVALUATION RESULTS, AND SUSTAINABILITY

Wayne Clark, Ph.D., the President of CalMHSA, provided the semiannual report from CalMHSA, a joint power authority formed to look at counties acting jointly to work together in activities that benefit all counties. CalMHSA is funded to administer PEI Statewide Projects on stigma and discrimination reduction, suicide prevention, and student mental health, and they provide T/TA and WET training activities.

Currently, 83.4 percent of the funding goes to programs. Independent audit findings for FY 2012-13 showed there are funds available into the next FY.

PEI Statewide Projects consist of three initiatives developed through a large statewide process. MHSOAC approved a plan put together by CalMHSA team to evaluate the three initiatives. The evaluation looks at PEI capacities and resources being developed and implemented, the intervention activities being delivered and to whom, the short-term outcomes, and the negative outcomes that are being reduced.

MHSOAC recommended that CalMHSA put together a team of experts, called the Statewide Evaluation Expert (SEE) Team, to provide research and evaluation guidance. The SEE Team meets quarterly with CalMHSA to review the activities of RAND, an independent research organization, and how they relate to counties.

Part of the Interim Evaluation Progress Report, released in the fall, provided baseline assessments of population risk factors and outcomes for suicide rates in California, a statewide survey of the general population, and higher education surveys. Dr. Clark stated, to make an impact on these issues, it is important to establish baselines to track the change over time.

The baseline assessment for suicide rates in California indicated that there was a higher rate of suicide in less dense counties. The highest numbers of suicide in population dense counties are in the southern part of the state and in several coastal communities.

The baseline assessment for the statewide survey of the general population served as a baseline measure of general population risk factors and an early measure of exposure to CalMHSA PEI efforts. Where possible, survey items were based on other large population-based surveys. The norms, attitudes, and behaviors of the citizens of California are important to measure as they change over time with regard to awareness, social distance, disclosure, perceived dangerousness, and suicide knowledge.

The baseline assessment for higher education surveys served as a baseline measure of student mental health, school environment, and student, staff, and faculty behavior and attitudes on mental health.

Dr. Clark reported the early data on CalMHSA's reach of activities through various media. The RAND Corporation measured the reach by intervention type on the number of persons who were directly trained and educated, the number of persons directly reached, the number of media impressions or views, and the number of people reached through informational resources, for a total of 290 million connections made.

Part of CalMHSA's public health approach to prevention and promoting mental health is to consider policies that could impact the way business is done and social norms. CalMHSA worked with the National Associated Press to improve their standards on accurate reporting on mental health, the state K-12 educator credential standards to include training on early identification of at-risk students, and the suicide prevention hotlines across the state to collect and compile common data elements.

CalMHSA put together stigma and discrimination reduction toolkits, trainings, and educational programs for diverse audiences. For suicide prevention, CalMHSA developed the Know the Signs campaign, social marketing, hotlines, and warmlines. For student mental health, CalMHSA developed training for educators, an online clearinghouse, a policy work group, cross-campus groups, online resources, and trainings for faculty, staff, and students. CalMHSA developed programs to reduce disparities and ensures that programs and contractors culturally adapt the programs to meet the needs of the diverse population in California.

Dr. Clark provided the evaluation conclusions to date from the RAND Corporation. RAND concluded that contractors have been highly productive in developing building capacities, early information on research is promising, short-term impacts are yet to be determined, population-based surveys and suicide statistics provide baseline information for longer-term tracking, implementation of statewide population-focused PEI strategy is challenging and ground-breaking, and evaluation approaches and tools may be useful for county-level PEI efforts.

Dr. Clark directed Commissioners to CalMHSA website for the report, supporting documentation, the RAND interim evaluation publications, and literature reviews.

He stated evaluation results will inform longer-term investment in statewide prevention. CalMHSA has been working with counties and contractors on a sustainability plan. A taskforce, set up last summer, will bring recommendations to CalMHSA Board in February. The criteria for rating current projects for sustainability are that they are

statewide, have a regional value, show evidence of impact, have leveraging potential, are evidence-based practices, and discontinue adverse consequences.

CalMHSA plans to continue with the Phase One Sustainability Plan through December 31, 2015. There are contingency funds, unspent funds, and funds that are obligated to contractors with a no-cost extension. Phase Two will consider new statewide activities as well as those currently implemented, and explore diverse funding options.

Dr. Clark introduced John Chaquica, the Executive Director of CalMHSA, Ann Collentine, CalMHSA Program Director, Stephanie Welch, CalMHSA Senior Program Manager, and Sarah Brichler, CalMHSA Program Manager.

Public Comment:

Mr. Gilmer, who was a proposal evaluator with CalMHSA, stated it was an arduous process and congratulated CalMHSA on the major beginning in changing attitudes, values, norms, and behavior relative to mental health. He stated his hope that Martin Luther King Jr.'s dream of changing racial, ethnic, and cultural communities' attitudes, norms, and behaviors is ongoing, and that additional resources will be allocated to public awareness and media strategies to produce a measurable impact in change and transformation in underserved communities.

Mr. Leoni stated he served on the SEE Team. Some good efforts have been made and some good starts begun. MHSA is about doing something special. Mark Ragins created the Village model, which is at the core of so much of what MHSA services are all about. Anti-stigma efforts help, but they have not shifted public climate as much as necessary. The anti-discrimination message will require continuous quality improvement. With regard to sustainability, evaluation needs to continue and it makes no sense to create materials off the shelf - as good as they may be - and then walk away. Circumstances change and things can always be done better. A longer-term haul, like Mark Ragins's work, would be worthy of what MHSA is all about. He urged the Commission to do what they can to help with the sustainability of the CalMHSA effort.

Commissioner Questions and Discussion:

Vice Chair Pating stated his concern about how the evaluation will dovetail, meet, or further larger MHSA goals. He liked the public health approach, but questioned the three potential outcomes at the end of the pilot funds: how to show which programs work, how to show the impact of statewide PEI, and how the evaluation projects facilitate and assist the burgeoning county PEI evaluation moving forward.

Dr. Clark stated, regarding showing what works, RAND's system of accountability ensures that contractors are accountable for what they are providing, and CalMHSA has been tracking that. Phase Two reviews what is working and the impacts seen program by program. The impact of statewide PEI goes back to accountability. Several of the counties have used the logic framework that RAND developed both in prevention and in the CSS programs to get a sense of what is being done, the short-term impact, and long-term outcomes. The ability to look locally, statewide, and at MHSAOAC evaluation efforts, enables the dovetailing and coordinating of efforts.

Ms. Welch added that the impact of the programs will come out in June in the Short-term Outcomes Report, where targets of change in knowledge, attitudes, normative behavior, mental and emotional wellbeing, and help-seeking will be evaluated by individual program, by component, and, collectively, as an entire investment in all three component areas. Beginning in March, RAND will submit internal memos on findings that CalMHSA will share with the Commission.

Commissioner Carrion asked if there are plans to disseminate the short-term findings to groups that could make these programs possible. He asked how to inform groups of CalMHSA findings so these programs can be disseminated.

Ms. Collentine stated CalMHSA will consider it because dissemination is a challenge they are currently faced with, and they will look for innovative opportunities to address it.

Commissioner Keith asked to what degree CalMHSA has been integrating their activities with local counties' activities geared toward similar purposes so there is no duplicative effort.

Ms. Collentine stated they are doing it as best they can. They are deeply involved with the dissemination, integration, and enhancement of local activities with statewide activities. It does not replace local activities, but it may enhance them, because CalMHSA has access to things counties do not have access to. CalMHSA is looking at how to work with counties to integrate that and how to get the tools they have developed deeper into the communities through counties and community-based organizations throughout the state.

Commissioner Boyd stated health systems are natural partners throughout the state to continue this work, not only because it is the right thing, but because it is mandated to fulfill this requirement. He stated he is looking forward to ongoing discussions about how to accomplish that. He asked how "directly reached" is defined.

Ms. Brichter stated this data, self-reported by the contractors, is broken out by four categories, such as how gatekeepers and individuals in the community who are likely to influence others are reached. That is the data about who was trained or directly reached. They include law enforcement officers, teachers, and other individuals who have a high likelihood to impact more community members. The "directly reached" is a variety of different numbers, such as individuals who called a suicide prevention hotline and reached out for help, or students on campus who were screened and may have been identified and received services on campuses as a result of the screening. The social marketing numbers are called "impressions" or "views," such as people who see the suicide prevention billboards along the freeway. The other number for "informational resources" tends to be website hits.

Commissioner Boyd asked CalMHSA to provide a breakdown of the "directly reached." He asked how they benchmark the cost-effectiveness and efficiency of the work they do.

Ms. Collentine stated it is a work in progress. CalMHSA has been in discussion with RAND about how that can be part of the evaluation efforts. There is prior economic research data on how other communities have measured prevention.

10. PRESENTATION ON “FOSTERING GROWTH IN CULTURAL AND LINGUISTIC COMPETENCE”

Sharon Jones, the Merced County MHSA Coordinator and Cultural and Linguistic Competency Committee (CLCC) Committee Member, stated relationships must be built first in order to foster growth, along with positive connections. The first critical needs of all people must be fulfilled in order to foster growth: to be respected, accepted, and included, and to feel important and secure.

Ms. Jones stated culture is a mindset that is ever evolving, carried from generation to generation. Cultural competence is the capacity to work across cultural differences in an effective manner and to value diversity. People are responsible on individual and organizational levels to work effectively in cross-cultural situations.

There are many cultural considerations, such as ethnicity, race, country of origin, and age. An essential element of cultural competence is valuing diversity. Cultural humility is respecting different points of view and engaging with others humbly and authentically. It results in the reduction of prejudice and oppression and opens opportunities for equality. The Surgeon General reported that individuals have different coping styles, help-seeking behaviors, and attitudes, and different ways of accessing community resources.

Cultural competence is necessary to gain a better understanding to ensure that appropriate assessments, diagnoses, and treatments are provided to culturally diverse communities. People generally do not address issues until they are brought into their awareness. Culture affects human behavior and influences psychological processes based on cultural background, experiences, attitudes, values, biases, and emotional reactions.

Everyone has a worldview representing beliefs, values, and assumptions about people, relationships, nature, time, and activity. Worldview affects how situations are perceived and evaluated. Everyone has a racial/ethnic identity that is connected to self-image.

Ms. Jones explained that the cultural competence continuum begins with cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, basic competency, and advanced competency. She stated the importance of recognizing ethnic, racial, and cultural stereotypes to minimize negative impact. Acculturation refers to how individuals adapt to contact between two cultures. Linguistic competence is also important to understand a diverse audience. There is a power imbalance between providers and consumers due to differing values, beliefs, and expectations. Biases also exist along with discrimination.

Shadeism is the discrimination between lighter- and darker-skinned members of the same community. Identity privilege, an unearned benefit or advantage, is also important when addressing cultural competence. White privilege results from an unidentifiable racial hierarchy that creates a system of social advantages primarily on race rather than merit. Colorism is discrimination based on skin color within groups. Nonverbal behavior is influenced by culture, age, gender, and situation.

Ms. Jones discussed disparities in treatment. Power is associated with authority. Those who have power are the gatekeepers to the resources. Health literacy is the ability to understand basic information and to process health information. She stated over 89

million American adults have limited health literacy. Health equity is health for all people.

She gave examples of health disparities for several cultures, and stated all groups of people have strengths. She showed slides with examples of cross-cultural strengths.

Barriers to service are stereotypes, power differentials, conflict in consumer-provider cultural values, racism, difficulty accessing services, failure to get the appropriate diagnosis or the right assessment, mistrust of the system, failure to be mindful of the historical context, and failure to acknowledge that change is needed.

Ms. Jones stated the need to be culturally sensitive and responsive to the families served. Multicultural awareness helps ensure appropriate assessments, diagnoses, and treatments, improved clinical outcomes, and more effective evaluations and assessments. Culturally responsive behavior leads to low attrition, high consumer satisfaction, motivation, utilization, and positive outcomes.

Vice Chair Pating asked staff to review the fifteen class standards to make the Commission a class-compliant organization.

11.REPORT ON USE OF PEI FUNDS FOR PREVENTION AND EARLY INTERVENTION

Elizabeth Harris, Ph.D., of Trylon Associates, stated the purpose of PEI Activities and Expenditures Study was to explore two of the key ways that MHSA funds prevent mental illness from becoming severe and disabling for individuals. The University of California, Los Angeles (UCLA) Team focused on PEI as it was worked in MHSA, making a distinction between how PEI funds were used and the impacts for those at risk of serious mental illness (prevention), and those experiencing early onset of mental illness (early intervention).

Dr. Harris stated the UCLA Team was tasked with determining by county and statewide the amount of MHSA PEI funds spent on prevention versus early intervention, who was served, the types of programs and activities being implemented, and their intended outcomes.

The Evaluation Advisory Group, composed of county representatives, determined the focus of study should be on FY 2011-12, and that additional data collection was needed. Expenditure data and number-served data were collected directly from the counties.

The final study categories went beyond prevention and early intervention. Stand-alone indirect, mixed, and out-of-study scope categories were added. Prevention was defined as activities that intend positive mental health outcomes for individuals at risk of serious mental illness. Early intervention was defined as activities that intend positive mental health outcomes for individuals with early onset of a serious emotional disturbance or serious mental illness. Stand-alone indirect programs and activities were defined as broad-based efforts that counties carry out in response to specific MHSA mandates for PEI that typically do not provide direct service to individuals. Out-of-study scope programs and activities were defined as programs and activities that did not meet study inclusion criteria for a prevention or early intervention program or for indirect activities consistent with MHSA purposes for PEI. Mixed programs and activities were efforts

where the counties could not separate out their prevention from their early intervention population.

Dr. Harris showed a series of charts depicting the number of counties, the number of programs and activities, and the number of participants in each study category. The number of counties implementing prevention programs had the highest percent at 76.3 percent. Stand-alone indirect and early intervention had the next highest percents at 71.2 percent and 67.8 percent, respectively.

Early intervention programs had the highest number of programs at 33.8 percent. Stand-alone indirect and prevention had the next highest percents at 28.9 percent and 25.5 percent, respectively.

Early intervention programs had the greatest number of participants at 63.0 percent. Prevention had the next highest percent at 36.8 percent.

Dr. Harris showed demographic slides of the age groups served by prevention and early intervention programs, listed by the number of individuals by age group. She stated that the majority of those served under prevention were children at 64.9 percent, and the majority of those served under early intervention were also children at 36.4 percent. She noted that, for early intervention, adults followed closely at 32.5 percent. Gender is an even split for both prevention and early intervention.

There is a difference between the prevention and early intervention groups for racial and ethnic communities served. For prevention, the plurality ethnic group was Caucasians at 38.1 percent, followed by Hispanics/Latinos at 29.2 percent and African Americans at 15.2 percent. For early intervention, the plurality ethnic group was Hispanics/Latinos, followed by Caucasians and African Americans.

The majority of PEI expenditures have gone to early intervention at 54.4 percent, followed by the stand-alone indirect efforts at 25.8 percent and prevention at 12.6 percent.

The return on investment was not part of the study charge. The Washington State Institute for Public Policy, funded by the Washington State Legislature to do independent cost-benefit work, conducted the analysis. Independent cost-benefit data is available on the Internet. UCLA reviewed their work to see if there were any projects under PEI done by the Washington State Institute for Public Policy. Any national evidence-based practice that they have done work on has to meet rigorous criteria. There are only fifteen evidence-based practices on the website, but the information is useful. There were approximately 25,000 individuals who received services in FY 2011-12. UCLA calculated the estimated return on investment at \$206.5 million after the costs were taken out. This study found there are potential financial benefits for offering sound PEI services, and there is value in looking further at the promising practices being implemented under PEI.

Chair Van Horn stated the \$300 million spent on prevention in California has more than paid for itself, based on the Washington study. He asked staff to calculate the number of people served by these programs in California by the estimated return on investment found in the Washington study, and then to extrapolate that figure to the rest of PEI programs, and assume they are only half as effective.

Dr. Harris stated the message to take away is that the Washington State Institute for Public Policy's national data clearly shows that prevention works. It is now a matter of investing in evaluation of other promising PEI practices to further that message.

Chair Van Horn stated the message that prevention pays for itself needs to be put out to Congress and the public.

Vice Chair Pating agreed and stated this major finding buried in the report pays for the whole report in terms of value. He asked for it to be pulled out so it will be easier to see, and stated it may require a separate white paper on this issue so it is highlighted.

Dr. Harris recommended that MHSOAC consider providing a standard definition for "at risk of a mental illness," in order to ensure that appropriate populations are being served. She also recommended that MHSOAC consider clearly defining "program" and "activity," and including requirements about reporting at the "activity" level so expenditures and numbers served can be documented in a more manageable way.

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist, stated the new PEI regulations address these issues specifically.

Commissioner Nelson asked why Native Americans were singled out as having an inherent tendency for mental illness. He asked if UCLA looked at the people or the situation.

Dr. Harris stated it was worded in the report, which was based on the literature, that it is due to historical trauma and the stigma and discrimination that comes with it. She encouraged Commissioners to review the table included in the report, which shows the thoughtfulness with which the counties approached their prevention programming and the risk factors that they selected.

Vice Chair Pating stated there are reports from the California Health Interview Survey (CHIS) that look at genetic stress. The CHIS is an annual report and may be valuable in terms of looking at unmet need. He suggested staff compare the CHIS findings to PEI demographic issues as an opportunity to validate that the CHIS is picking up the things that the Commission deems relevant or important since there are specific population data that could match up.

Commissioner Carrion stated his appreciation for Dr. Harris's second recommendation, as it not only applies to evaluation and outcomes, but, upon implementation and dissemination, many counties may be able to engage in activities without having to implement the whole program, which will save a lot of money.

Commissioner Poaster asked staff to disseminate Dr. Harris's report to the counties. He asked Ms. Shilton to pass on the nice words that have been said to CMHDA.

Commissioner Miller-Cole asked, in making them more specific, whether the new PEI regulations are still broad enough to accommodate new information.

Dr. Bradley affirmed they were broad enough to allow for the developing literature. Dr. Harris used the target populations of the current PEI programs as her starting point. It was not an exhaustive search of every possible target population or risk factor.

Dr. Lee added that there is no pre-defined menu of risk factors in the regulations. The counties can identify any risk factor as long as it is a documented risk factor and there is

evidence that their proposed approach is likely, for a prevention program, to reduce the risk for that population, or, for an early intervention program, that it is likely to improve the mental health outcomes for that population.

Commissioner Boyd referenced Dr. Harris's surprise that prevention was reasonably lower than early intervention. He stated the population groups were also a surprise as it relates to, for instance, prevention, with the highest percentage being Caucasian, and the alignment of early intervention.

Dr. Harris stated the focus was on the findings for early intervention. She stated she could go back to look at the specifics of those prevention programs, which would probably answer a number of questions. She added that, given where the programs were implemented, the demographics would typically be different.

Commissioner Boyd agreed that the prevention numbers in those areas should reflect a different demographic. He asked if there were other places where populations, such as lesbian, gay, bisexual, and transgender (LGBT), are tracked as a separate classification within the context of diversity.

Dr. Harris stated it is in the report, but not all counties reported it. She added that the lack of data is probably due to lack of reporting rather than lack of serving people. The new PEI regulations will address this issue.

Dr. Bradley stated the cost savings in the Washington State Institute for Public Policy report are expected cost savings, based on costs and expected savings that were calculated using programs outside of California. It would be great to take the next steps to track, monitor, and evaluate the California programs that would enable those same calculations to ensure that not only those evidence-based practices that have been established by the Washington State Institute for Public Policy, but any and all of the California PEI programs could be evaluated for potential cost savings and cost benefits. The potential savings are speculative based on costs and savings calculated for other programs outside of California.

Public Comment:

MaryAnn Bernard, of the Mental Illness Policy Organization (MIPO), suggested the Commission include two things that are required by statute into the proposed PEI regulations: to require a diagnosis of mental illness for PEI programmatic provisions, and to designate PEI funds for people who are already severely mentally ill. Instead, the money has funded programs that do not require a diagnosis, such as gardening and horseback riding.

Commissioner Boyd reminded everyone, including speakers, of the tremendous amount of work the staff does. He asked that people treat staff appropriately and with respect, including when they notify when limitations of time for speaking has ended.

12. GENERAL PUBLIC COMMENT

Stacie Hiramoto, the Director of REMHDCO, stated many of the prevention and early intervention services that were mentioned in the last testimony, such as gardening and horseback riding, have served underserved racial and ethnic communities well. They

are treasured and appreciated by those communities. The programs are effective and are not against the intent of MHSA.

Ms. Zinman stated her concern over the rampant discrimination and stigma that is occurring across the country, the atrocities that are going unpunished, and the outbreak of scapegoating people with mental health issues for the violence in the country.

13. COMMISSIONER COMMENTS

Discuss Future Commission Agenda Items

Commissioner Boyd suggested reviewing the core functions of Commission meetings and how the community forums and the work of the Commission meetings are used.

14. ADJOURN

There being no further business, the meeting was adjourned at 3:35 p.m.