



State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting
August 28, 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 Boyd, Psy.D.
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

Sheriff William Brown
Senator Lou Correa
Assemblymember Bonnie Lowenthal
LeeAnne Mallel

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
Jennifer Whitney, Director of Communications
Jose Oseguera, Chief of Plan Review and Committee Operations
Norma Pate, Chief of Administrative Services
Lauren Quintero, Manager
Kristal Carter, Staff Services Analyst
Cody Scott, Office Technician

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 8:33 a.m. and welcomed everyone. Kristal Carter, Staff Services Analyst, called the roll and announced a quorum was present.

ACTION

1A: APPROVE JULY 24, 2014, MHSOAC MEETING MINUTES

Commissioner Keith noted that Commissioner Miller-Cole's last name was misspelled in Item 1A.

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

The MHSOAC approves the July 24, 2014, Meeting Minutes.

- Motion carried, 10-0

INFORMATIONAL

1B: July 24, 2014, Motion Summary

1C: MHSOAC Evaluation Dashboard

1D: MHSOAC Calendar

ACTION

2A: APPROVE TRI-CITY INNOVATION PLAN

Presenters:

Jose Oseguera, MHSOAC Chief of Plan Review and Committee Operations

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist

Jose Oseguera, Plan Review and Committee Operations Chief, introduced Dana Stein, the Mental Health Services Act (MHSA) Coordinator of Tri-City Mental Health. Tri-City is a subset of Los Angeles (LA) County and is comprised of Claremont, Pomona, and La Verne Counties. Tri-City is requesting \$1,580,938 for a three-year period for two innovative programs entitled "Cognitive Remediation Therapy Program" (CRTP) and "Employment Stability Program" (ESP).

The CRTP is designed to increase the quality of services and measure outcomes for individuals suffering from severe mental illness by treating the whole person through combining two evidence-based practices: Cognitive Enhancement Therapy (CET) and Cognitive Behavioral Treatment for Psychosis (CBTfP). The CRTP tests the possibility of reducing the length of disorders, leading to improved quality of life. A Recovery Learn Team (RLT) will assess the program, and review and document findings.

The ESP is designed to promote interagency collaboration between Tri-City and local employers in support of employment programs. The goal of this Innovation (INN) Program is to reduce stigma, prevent job loss, and increase employment opportunities. It will build new relationships and understanding, incorporate employers into the system of care, and use a wellness-focused approach to address cultural differences and self-stigmatizing beliefs. Tri-City will conduct pre- and post-testing to evaluate changes in employers' attitudes and knowledge regarding employment of mental health consumers by looking at employment policies, procedures, and protocols.

Dr. Deborah Lee, Consulting Psychologist, summarized the contribution to the field of each of the programs. She stated the CRTP is a serious contribution in that it combines two practices and addresses the cognitive and symptom-functioning aspects of psychosis. It will reduce barriers to services and shorten the timeframe of disorders.

The ESP's key contribution is to bring employers in as partners, for a three-way partnership among clients, the mental health system, and employers to adapt curricula and to work together toward goals.

Dr. Lee stated the Tri-City INN Programs meet all MHSA requirements for an innovative program. Staff recommends approval.

Commissioner Questions and Discussion:

Commissioners Aslami-Tamplen and Wooton asked if the CET team and the RLT included consumers and family members. Dr. Lee stated consumers are a key element.

Commissioner Aslami-Tamplen asked if the ESP will measure how it helped reduce stigma with employers. Ms. Stein answered in the affirmative.

Commissioner Nelson asked if the combined treatments will reduce the length of the disorder or the length of the acute episode. Dr. Lee stated they will reduce the length of the acute episode.

Commissioner Carrion encouraged including a midpoint assessment. Dr. Lee agreed that evaluation and assessment should be done throughout the process.

Action: Commissioner Poaster made a motion, seconded by Vice Chair Pating, that:

The MHSOAC approves the Tri-City Innovation Plans for the amount of \$1,580,938 over a period of three years.

- Motion carried, 10-0

ACTION

3A: APPROVE GLENN COUNTY INNOVATION PLAN

Presenters:

Jose Oseguera, MHSOAC Chief of Plan Review and Committee Operations
Deborah Lee, Ph.D., MHSOAC Consulting Psychologist

Jose Oseguera, Plan Review and Committee Operations Chief, introduced Amy Lindsey, Deputy Director of Glenn County Behavioral Health; Roxann Baillergeon, MHSA Program Coordinator of Glenn County Behavioral Health; and Nancy Callahan, Ph.D., owner of Innovative Development and Evaluation Associates (IDEA) Consulting.

Glenn County is requesting \$816,344 for a three-year innovative program, entitled "System-Wide Mental Health Assessment Response Team" (SMART), to promote interagency collaboration, with staff from mental health, probation, law enforcement, and the schools, for suicide prevention and school safety. The SMART staff will respond to critical incidents involving students with early onset or who are at risk of mental illness and will train, screen, intervene, and provide case management to students involved in those incidents. This program will measure the effectiveness of collaboration across agencies by using the Interagency Collaboration Activities Scale (IACAS).

Dr. Lee stated that this INN Program adapts a collaborative response to the mental health dimensions of critical incidents for a rural county. Glenn is a small county and does not have the resources for dedicated staff; the county must collaborate in order to develop a coordinated, consistent, systematic response and follow-up. Their contribution to the field will be the applicability of their program to other rural counties.

Dr. Lee stated the Glenn County INN Program meets all MHSA requirements for an innovative program. Staff recommends approval.

Commissioner Questions and Discussion:

Commissioner Keith asked how the mental health issues of students will be identified. Dr. Lee stated there will be a consistent screening program and a consistent response to incidents. Dr. Callahan added that stakeholders are concerned about school threats and bullying. SMART will develop a systematic method to identify, respond to, and resolve these issues.

Commissioner Aslami-Tamplen asked if youth peer mentors will be part of the program. Dr. Callahan answered that peer mentors and adult advocates will be part of SMART. These are paid positions from a federal Substance Abuse and Mental Health Services Administration (SAMHSA) Children System of Care Grant.

Commissioner Gordon asked about the levels of the school system in which the program will operate. Dr. Callahan answered that SMART will be system-wide.

Commissioner Miller-Cole asked if SMART will address the needs of lesbian, gay, bisexual, transgender, questioning (LGBTQ) youth who are at increased risk for bullying. Dr. Callahan answered that the transition-age youth program has been active in this area and partners with the Butte County Stonewall Alliance to create shared programs.

Action: Commissioner Aslami-Tamplen made a motion, seconded by Commissioner Keith, that:

The MHSOAC approves the Glenn County Innovation Plan for the amount of \$816,344 for three years.

- Motion carried, 10-0

ACTION

4A: APPROVE INYO COUNTY INNOVATION PLAN

Presenters:

Jose Oseguera, MHSOAC Chief of Plan Review and Committee Operations
Deborah Lee, Ph.D., MHSOAC Consulting Psychologist

Jose Oseguera, Plan Review and Committee Operations Chief, stated that Inyo County is requesting \$322,800 for a three-year innovative program, titled “Coordinated Care Collaborative” (CCC). This plan will increase the quality of services and improve outcomes for adults with serious mental illness by increasing access to and coordination with primary care services for clients with a serious mental illness, and to develop strategies to promote wellness and integrate health care, mental health, and substance use services to improve health outcomes for clients in rural communities.

This project will also highlight the role of peer support and will study whether and how this is a culturally sensitive, effective, and cost-effective way to achieve goals. The CCC will test whether and how the coordinated care approach improves coordination of, and satisfaction with, care and improved health outcomes. It will also measure changes in clients’ health indicators, fulfillment of wellness and recovery goals, use of self-management skills, and peer support.

Dr. Lee added that Inyo is a small rural county with limited resources looking at how to integrate health care in a rural context by collaborating with rural clinics; improving the

coordination of system measures; incorporating physical, behavioral, and mental health issues; focusing on wellness and peer support; evaluating client outcomes and system outcomes, changing the feedback, communication, and data systems; and testing cost-effectiveness.

Dr. Lee stated that the Inyo County INN Program meets all MHSA requirements for an innovative program. Staff recommends approval.

Commissioner Questions and Discussion:

Vice Chair Pating stated that the rural element is what is new and unique. Dr. Lee agreed that Inyo County is working out how to apply successful approaches in a rural context.

Commissioner Nelson asked if the county's Native American population is included in the plan. Dr. Lee stated that one of Inyo County's key partners is the Toiyabe Native American Health Clinic, which is part of their collaboration.

Commissioner Aslami-Tamplen asked if training is offered to peer support, and if the effectiveness of peer support is evaluated. Dr. Lee stated that the Wellness Recovery Action Plan (WRAP) and sharing WRAP results with providers are key elements of Inyo's approach.

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

The MHSOAC approves the Inyo County Innovation Plan for the amount of \$322,800 for three years.

- Motion carried, 10-0

ACTION

**5A: PROPOSED PREVENTION AND EARLY INTERVENTION REGULATIONS:
RESPONSE TO PUBLIC COMMENT**

Presenters:

**Filomena Yeroshek, MHSOAC Chief Counsel
Deborah Lee, Ph.D., MHSOAC Consulting Psychologist**

Chair Van Horn, Vice Chair Pating, and Commissioner Poaster expressed their appreciation to MHSOAC staff for their work on the Prevention and Early Intervention (PEI) Regulations and to stakeholders for providing their input.

Filomena Yeroshek, Chief Counsel, displayed one of six four-inch binders with double-sided pages filled with the public comments and other supporting documentation on the PEI Regulations and stated Commissioners will only consider Section 3705 through 3740 today. The remainder of the Section will be presented in a future meeting.

Ms. Yeroshek stated the Commission adopted the proposed PEI Regulations on November 21, 2013. On June 6, 2014, the Office of Administrative Law (OAL) published the proposed regulations. A public hearing was held on July 24, 2014, which was also the end of the forty-five-day public comment period. Today, the Commission will possibly make changes or vote to adopt the regulations, limited to Section 3705 to 3740. There will be an additional fifteen-day public comment period on any proposed changes that the Commission makes. The proposed time line is that the Commission will adopt the proposed PEI Regulations in November 2014, or December 2014, and staff will submit the rulemaking file

to the OAL. The OAL will have thirty days to determine if the Administrative Procedure Act standards were met.

Ms. Yeroshek explained the structure for today's discussion. Commissioners will vote on staff's nineteen recommendations for changes to Sections 3705 to 3740, based on public comments, and then will vote on staff's rejections of public comments. Members of the public will be given an opportunity to comment on the motions.

Ms. Yeroshek reviewed the seven steps outlined in a document titled "Prevention and Early Intervention Regulations Decision-Making Process for the August 28, 2014, MHSOAC Meeting." She emphasized that today's public comment is limited to why staff's recommendations should be accepted or rejected. If the Commission decides to change language to the proposed regulations, the public will have an opportunity during the fifteen-day public comment period to provide comment on the changes. The Commission will vote on staff's recommendations to the comments received during the fifteen-day period in the October meeting.

Staff's Suggested Changes

Dr. Lee reviewed a document titled "Proposed Prevention and Early Intervention Regulations, Sections 3700 through 3740," which outlined staff's nineteen recommended changes.

In new Section 3701(a) and Section 3702(a), staff added definitions of a "program," a stand-alone effort, and a "strategy," the method within a program, because the terms are used inconsistently in the MHSA.

In Section 3705(a)(c), in response to numerous comments, staff added the requirement for at least one prevention program, with the exemption of small counties. "Small counties" means "a county in California with a total population of less than two hundred thousand," according to the most recent projection by the California State Department of Finance (DOF).

In Sections 3705(b)(2) and (3); 3725; and 3730, staff recommended deleting the term "approach" from the name "program/approach." The new definition of "program" includes "approach."

In Section 3710(b), staff recommended a requirement that early intervention include relapse prevention.

In Section 3710(c)(1), staff recommended adding the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V), definition of a "serious mental illness or emotional disturbance with psychotic features" for consistency.

In Sections 3710(f) and 3720(f), staff recommended adding the clarification that counties may combine an early intervention program with a prevention program, as long as the requirements for both programs are met. This is a change for consistency within the regulations.

In Sections 3710(g), 3715(g), 3720(g), 3725(c), and 3730(d), staff recommended the clarification that all programs in these Sections shall include all of the strategies listed in Section 3735. This change adds a cross-reference and makes no substantive change.

In Section 3715(c), staff recommended including "visiting nurses, family law practitioners such as mediators, and child protective services" to the list of possible responders.

In Section 3715(f), staff recommended adding that it is permissible within PEI for the requirement for outreach to individuals who can identify early signs and symptoms of a

mental illness to be fulfilled through another MHSA component, as long as it meets all of the requirements for PEI, in both the statute and the regulations.

In Section 3720(e)(1), staff recommended clarifying the definition of “universal prevention” for consistency within the regulations.

In Section 3725(b)(1), staff recommended clarifying that the example of “multiple stigmas” refers to “those that have been shown to discourage individuals from seeking mental health services.” The suggested language clarifies that addressing multiple stigmas overlaps with issues in the law related to mental-illness-related stigma and with issues related to seeking mental health services, which are the two purposes in the MHSA for stigma and discrimination reduction.

In Section 3725(b)(2), staff recommended adding clarification that all approaches must be culturally congruent with the values of the target population.

In Section 3730(c), staff recommended adding “survivor-informed models” to the list of examples of suicide prevention programs.

In Section 3735(a)(2)(B), staff recommended adding “shelters” to the list of examples of settings that might increase timely access to mental health services for underserved populations.

In Section 3735(a)(1)(B), staff recommended clarifying that counties are required to provide access and linkage to treatment for individuals with a severe mental illness for all PEI programs, and have the additional option to offer a stand alone program for this purpose.

In Section 3735(a)(2)(C), staff recommended adding that counties have the option to offer, in addition, a program to improve timely access to services for underserved populations.

In Section 3735(a)(3)(B), staff recommended adding the word “factual” to modify “messages” and the word “practices” to the list of culturally appropriate language and concepts.

Commissioner Clarifying Questions:

Commissioner Aslami-Tamplen stated that outreach is critical under PEI. She asked for clarification, under Section 3715(f)(1), that outreach is mandatory but may be included in other programs.

Ms. Yeroshek stated subdivisions cannot be read alone. Section 3715(a) says that it is a requirement for a county to have an outreach for increasing recognition of early signs of mental illness. The new subdivision (f) says that the required program may be provided and funded through other components.

Chair Van Horn added that the end result of this change is that community services and supports (CSS) dollars can be spent on PEI-conforming outreach. If one percent of CSS dollars is spent on PEI-conforming outreach, then the twenty percent of PEI dollars is still available to be spent on PEI.

Commissioner Carrion asked for verification, under Section 3725(b)(1), that stigma is not being defined as “those events that discourage individuals from seeking mental health services.”

Dr. Lee clarified that the three contextual statements in the law are stigma and discrimination associated with being diagnosed with a mental illness; stigma related to seeking mental health services; and discrimination related to having a mental illness. This change lists examples of ways that a county might ensure that all of its programs are

contributing to the reduction of stigma and discrimination. One of the ways is addressing multiple stigmas, which ties it back to the MHSA purpose.

Commissioner Keith stated, under Section 3710(c)(1), “include” should be “including.” Dr. Lee stated it was directly quoted from DSM-V. She stated she will check the reference.

Vice Chair Pating stated there is a mandatory requirement that all PEI interventions include three strategies: access and linkage to treatment, improve timely access, and strategies that are non-discriminating. He stated he had felt that “in addition” should be “instead” in Section 3735(a)(1)(B), but staff had clarified it for him. He asked them to repeat the explanation in case others questioned it.

Ms. Yeroshek stated this is one of the reasons for defining “program” and “strategy.” Section 3735(a) states counties “shall include strategies,” and 3735(a)(1)(B) states that counties may offer a program in addition to the strategies.

Chair Van Horn stated counties have the responsibility to include strategies that will increase access and linkage in all of their prevention programs. However, they may also, offer a separate program that focuses on access and linkage.

Vice Chair Pating suggested some non-substantive clarifying changes. Ms. Yeroshek suggested “may also offer.” Vice Chair Pating suggested “in addition to these strategies, they may also offer a specific program.”

Vice Chair Pating stated Section 3701 defines “program” as “likely to bring about mental health outcomes.” He stated everything will bring about a mental health outcome, including doing nothing, which may be positive, neutral, or negative. He suggested making a non-substantive clarification of “likely to bring about positive mental health outcomes.”

Commissioner Aslami-Tamplen stated her concern about the exemption for small counties and what will be eliminated if small counties “may” have a prevention program with access and linkage being a part of prevention.

Commissioner Gordon stated there are thirty counties with a population of two hundred thousand or less.

Dr. Lee stated access and linkage is required of all counties. Prevention is a program serving individuals at the point of risk. The proposed change would mean that counties are not required to offer a program that serves individuals at risk. Current guidelines do not require counties to offer a prevention program or an early intervention program. It is optional for a county to offer one or both. She stated approximately eighty percent of all counties offer a prevention program, and approximately eighty percent of all counties offer an early intervention program. Even without a requirement, most counties offer both.

Dr. Lee stated the definition of “very small county” is a county with a population of less than one hundred thousand people. Commissioner Gordon stated there are twenty-three counties with a population under one hundred thousand people.

Commissioner Aslami-Tamplen stated the term “very small counties” is more acceptable than “a population of two hundred thousand.” She suggested adding the word “very” in front of “small counties” in Section 3705(a)(3)(A), and defining “very small counties” as “counties with a population of one hundred thousand and under.”

Vice Chair Pating encouraged Commissioners against creating a new definition of “small county,” as it is a government definition, and to accept the staff changes as currently put forward.

Commissioner Wooton stated her concern that some counties may not be able to implement a prevention program due to the amount of MHSA funding they receive.

Dr. Lee agreed that some counties have fewer resources. She stated counties are not currently required to offer a prevention or an early intervention program, but prevention is important, has much research associated with it, and the MHSA references both prevention and early intervention programs, suggesting there is an intention to do both. The disadvantage of requiring both programs is it locks counties with fewer resources into having to do both, but the vast majority of counties are currently doing both programs.

Commissioner Gordon asked if the small counties ever collaborate for a prevention program. Dr. Lee stated it is encouraged for prevention, early intervention, and innovation programs. Most counties have not formally collaborated, but many small counties have forums where they support each other.

Commissioner Boyd asked if there is a prescribed structure for a prevention program. Dr. Lee stated the OAL prescribes an outcome-focused approach and the MHSA is structured that way. The only requirements are that the outcomes in the MHSA must be addressed, effective practices must be used, and evidence must be demonstrated on the effectiveness of meeting those outcomes.

Ms. Yeroshek stated the PEI Regulations do not prescribe methods - that is up to the counties - but there are definitions that have to be met in order for it to be called a prevention program, such as in Section 3720.

Commissioner Boyd asked if early intervention activities assist and support prevention. Dr. Lee stated the difference between early intervention and prevention in the regulations is prevention is intervening at the point of risk, which is defined as either individual risk or a membership in a group for which there is evidence of greater than average risk of developing a potentially serious mental illness. Early intervention is defined as intervening at the point of early onset in the development of a serious mental illness. Prevention is reduction of risk, and early intervention is the reduction of symptoms. The only difference is the point of intervention.

Commissioner Aslami-Tamplen asked if a mental health first aid program or a program about universal prevention efforts and education can be a prevention program.

Dr. Lee stated mental health first aid is not a prevention program. It would be increasing either “outreach to people in a position to recognize signs and symptoms,” “links to treatment,” or “timely access to services for underserved populations.” A prevention program is a specific intervention with individuals who are at risk of developing mental illness. A mental health first aid program would be in the other bucket of prevention programs that are broadly trying to increase access.

This is a very significant change in the regulations. Previously, there were broad buckets of prevention and early intervention, but there is a whole other category in the MHSA of much broader access strategies that do not focus on specific individuals, and those are covered under those other categories.

Commissioner Gordon asked staff to look, during the public comment period, at the seven counties that have a population under one hundred thousand to see how many now have prevention programs.

Commissioner Poaster added a request that staff also look at the PEI allocations for those counties or bring in the MHSOAC Financial Report.

Public Comment:

Joy Torres, of Right to Treatment, Child and Adolescent Action Center (CAAC), National Alliance on Mental Illness (NAMI), Orange County, stated her rejection of the motion.

Kendra White, of Our Village, thanked the Commission for breaking the stigma of state workers and for listening to the public comments and considering them for the regulations. She stated she agreed with the staff recommendations, but does not agree to the changes Commissioners are making today.

Poshi Mikalson, of Mental Health America of Northern California, stated her preference that one motion not cover all changes. She stated she supports the amendment that may be coming forward.

Raja Mitry, of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the California MHSA Multicultural Coalition (CMMC,) stated Section 3702 defines “strategy” as “a planned and specified method within a program intended to achieve a defined goal.” He encouraged the Commission to specify whose goal and what that goal is, and that it align with communities, families, and values of culture, gender, and generational roles, as well as considering sexual orientation and gender identity.

Michael Helmick, the Program Assistant of the REMHDCO, stated he was speaking on behalf of Wesley Kazuo Mukoyama. He stated he opposed the definition of an early intervention program as defined in Section 3710(c)(1).

Chair Van Horn stated the definition is from the DSM-V.

Mr. Helmick stated the definition of “serious mental illness” is too narrow, restrictive, and outdated in regards to mental health services. To restrict the definition of “serious mental illness” to psychotic disorders only rejects the work needed to a population that is in high need.

Ms. Yeroshek stated it is necessary to look at where the quotes are. The quote starts “serious mental illness or emotional disturbance with psychotic features.” That’s the definition. The definition is not a “serious mental illness.”

Dr. Lee added that it is a definition of a specific subset of serious mental illnesses called “serious mental illness with psychotic features.” It is not the definition of “serious mental illness.” The definition of “serious mental illness” is defined in the MHSA, and it is defined in Welfare and Institutions Code Section 5600.3, which is referred to, so it is a cross-reference.

David Czarnecki, the Advocacy Coordinator of NAMI, California, stated between forty-seven and fifty-one percent of counties are not directed to have a prevention program. He asked if small counties could opt to terminate these programs under these regulations, and if cost-effective, evidence-based prevention efforts should be developed with the small counties that were excluded or be given technical assistance to provide them with the ability to do prevention.

Chair Van Horn stated Mr. Czarnecki’s questions will be answered when staff returns with the data about defining these small counties and who is doing what.

Noemi Castro, the Assistant Director of the REMHDCO, stated that REMHDCO supports staff recommendations to add Section 3705(a)(3) and 3720(a) requiring counties to administer one or more prevention programs. She stated the REMHDCO provided extensive rationale as to why they support it during the forty-five public comment period.

Ms. Castro stated that REMHDCO opposes the addition of 3705(a)(3)(A) that would exclude small counties, but supports the possible amendment that would reduce the amount to one hundred thousand.

Mary Ann Bernard, of Mental Health Policy Organization, stated the motion should be rejected. She stated her concern that decisions are being made too quickly and that the

severely mentally ill are being left out of funding. She read a counter-motion that she had prepared and distributed copies to Commissioners.

Yvette McShan, the CEO of Victorious Black Women and CMMC, stated she opposes Section 3705.

Laurel Benhamida, of the REMHDCO Steering Committee, agreed with Raja Mitry, Posh Mikalson, Wes Mukoyama, David Czarnecki, and Noemi Castro's statements.

Jessica LePak, of the CMMC, agreed with Raja Mitry's statement regarding Section 3702, and she requested that the word "client" be added to it, to read, "a client-defined goal." She stated she opposed the motion because she would prefer each addition be discussed and voted on separately as opposed to one motion incorporating all changes.

Nicki King, Ph.D., of the University of California, Davis, and the California Reducing Disparities Project (CRDP), stated she opposes the motion. In Section 3725(b)(2), there was an attempt to include the public comment. She stated it should say "... populations being served," not "... populations for whom changes in attitudes, knowledge, and behavior are intended." Having that last clause in there makes it difficult to understand and defeats the purpose of having the clause at all.

Angela Brand, the Director of Public Policy and Information of the United Advocates for Children and Families (UACF), thanked the Commission for the addition of 3705(a)(3) with the prevention program mandate. She stated the UACF supports the proposed motion, but opposes the addition of 3705(a)(3)(A) for the small county exemption.

Jim Gilmer, representing the co-chair of the CMMC and the REMHDCO, stated he opposed the motion and would like the process to be slowed down, because terminology is important and critical when focusing on reducing disparities.

Rocco Cheng, Ph.D., the Corporate Director of Prevention and Early Intervention Services of the Pacific Clinics, acknowledged the hard work done on this summary. He stated his concern that one motion covers all changes.

Adrienne Shilton, the Program Director of the California Institute for Behavioral Health Solutions (CIBHS) and the County Behavioral Health Directors Association (CBHDA), stated - the CIBHS and CBHDA supports staff's recommendations and the proposed motion. The small county issue is about capacity, resources, and funding and, while the majority of counties, including the small counties, have funded prevention programs, there may be times, in the future, when limited funding would only allow an early intervention program that is supported by stakeholders. She encouraged the Commission to keep that language in the regulations as it is.

Commissioner Discussion:

Commissioner Aslami-Tamplen stated that prevention programs are very important and is part of the reason the MHSA was fought for. Preventing serious mental illness is a cost-savings for counties.

Commissioner Nelson asked if staff retrieved the data for Commissioner Poaster. Commissioner Poaster stated that moving from two hundred thousand to one hundred thousand affects seven counties. Five of those counties have prevention programs already. There are twenty-four counties that have less than one hundred thousand people and the great majority of those counties have prevention programs.

Chair Van Horn agreed that the data shows that counties have prevention programs anyway.

Commissioner Boyd asked why prevention, which is a core component, should not be a requirement since five of the smaller counties already do it. He asked, if prevention programs can be achieved by ensuring that counties collaborate more closely to do this work, why the Commission wouldn't want to adopt something that pushes more in that direction.

Chair Van Horn agreed that there should be further dialogue on this issue before locking it into the regulations to later be regretted.

Vice Chair Pating stated that the PEI Regulations have moved from "counties may" to "counties shall" have prevention and early intervention programs. That is a big accomplishment that makes a clear statement that the Commission supports prevention. There is good commitment from counties that, if they can do it, they are willing to do it. The regulations allow some flexibility for small counties to opt in and out as they can. To lock the requirement in for all counties is a concern. The Commission has made a strong statement while allowing some flexibility that will make it doable.

Commissioner Buck agreed with having flexibility for the very small counties. Counties do work together. It can be done.

Action: Vice Chair Pating made a motion, seconded by Commissioner Poaster, that:

The Commission adopts Staff's suggested changes to Proposed Prevention and Early Intervention Regulations Section 3700 through 3740 and the additional non-substantive changes to 3701, 3710, and 3735.

- Motion carried, 9-0, with 2 abstentions

Staff's Suggested Rejections of Changes

Ms. Yeroshek stated staff prepared a 152-page matrix that provides all of the public comments on Section 3705 through 3740 of the proposed PEI Regulations and staff's rationale for rejecting the comments.

Public Comment:

Ms. Torres stated she has noticed, since 1980, that the definition of someone with a severe persistent mental illness and someone who has a psychosis are two different things. Under intervention, prevention and early intervention should be intervening when a person is in a psychosis. She stated her concern that there is no definition as to what constitutes treatment for someone with schizophrenia. She stated stigma and discrimination are one of the prevention and early intervention strategies, but is more stigmatizing and discriminating towards people with severe mental illness.

Ms. Mikalson provided a comment related to the previous section due to a misunderstanding. In Section 3725(b)(1) that says, "... efforts to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services," she suggested adding "including, but not limited to, provider-based stigma and discrimination due to the client's actual or perceived sexual orientation, gender identity, race, ethnicity, age, or religion."

Research by the Reducing Disparities Project for LGBTQ individuals in California found that one of the top problems reported by those individuals when seeking services was that the mental health provider made negative comments about their sexual orientation or gender identity. One of the top barriers to seeking mental health services was concern that the mental health provider would not be supportive of their identity or behavior. It is also

important to note that among the top barriers to seeking services was the concern that the mental health provider would mistreat them due to their race or ethnicity.

Chair Van Horn agreed that there are many providers who are very stigmatizing.

Mr. Mitry stated he failed to expand on how serious complex and multiple losses are when he submitted his public comment about the inclusion of loss on Section 3720(c), regarding the risk factors for mental illness. He stated he did not imply, in his submitted public comment, that loss and isolation are the same. Even though loss is a universal human experience, multiple and severe losses, such as loss of relationships from violence, war, loss of homeland, loss of connection with ones culture often constitute trauma and leads to fragile outcomes and major disorders. That needs to be recognized. It is important in the regulation language that these multiple and complicated losses with greater-than-average risk factors experienced by people of all ages and among many diverse ethnic and cultural groups can be effectively addressed with prevention and early intervention strategies. He emphasized that his submitted public comment was about complex multiple losses of severe nature, not universal loss experiences.

Stacie Hiramoto, the Director of REMHDCO, agreed with Ms. Mikalson and Mr. Mitry's statements.

Ms. Bernard stated there are only two groups of people that are covered by PEI: people who have an existing mental illness that is in danger of becoming severe mental illness, and people who are already severely mentally ill, who are supposed to get relapse prevention programs. The regulations have completely cut the latter group out of the twenty percent PEI funding. Ms. Bernard suggested changing the "may" to "shall" in Section 3720(d).

She stated the importance of reading the public comments directly because the summaries are misleading. She stated she opposed the motion, and suggested the Commission give more thought to a process that should have began ten years ago and that the Commission is trying to do the PEI Regulations too quickly.

Ms. McShan commended Commissioner Aslami-Tamplen for speaking up.

Ms. Benhamida agreed with Mr. Mitry's statement. She stated complex loss, loss of homeland, neighborhood, family members, career, and so on, is often seen with refugees and immigrants. She gave several examples of refugees who have lost everything.

Ms. LePak agreed with Ms. Mikalson and Mr. Mitry's statements. She suggested including "persons with disabilities" to Ms. Mikalson's list because persons with disabilities also experience perceived provider stigma, and is a barrier to services. She agreed with Ms. Mitry's statement that severe, complex traumatic losses are a unique risk factor for some communities that should be reflected in the regulations.

Ms. Brand agreed with Mr. Mitry and Ms. Mikalson's comments.

Mr. Gilmer agreed with Commissioner Boyd that if having a prevention program is now a "shall," there needs to be some teeth behind it. He stated his hope that the Commission will further explore exempting counties, because prevention is one of the main means of reducing disparities and bringing the people to the table.

He stated he had given a comment on page six on the social determinants of health. The regulations contain some terminology around trauma, violence, and racism. He asked the Commission to continue to explore that and expand upon it throughout all the MHSA social determinants of health. He suggested putting together a think-tank or workshop to bring people together to explore that piece.

Commissioner Discussion:

Vice Chair Pating asked for clarification on the “loss” issue from Mr. Mitry and several others. Dr. Lee stated this was a comment regarding the list of examples of risk factors. The suggestion was to add “loss” to the list of risk factors. Staff’s response was that, while loss can be a risk factor, it was too ambiguous to add to the list of examples. She suggested adding “repeated traumatic loss” to the list of risk factors.

Commissioner Buck stated it seemed like a big issue and he agreed with adding something like “repeated and complicated loss” to the list of examples.

Commissioner Poaster asked if this is a substantive or non-substantive change. Ms. Yeroshek stated, since it is a change, it would go out with the other changes for the fifteen-day notice.

Dr. Lee asked if the Commission had the option to make its own suggestion. That would be accepting staff’s recommendation to reject the comment, but making its own amendment to the motion to add “complicated and traumatic loss” to the list of examples.

Ms. Yeroshek stated Commissioners have that option. It will continue to say “examples including, but not limited to.” It will simply be another one of the examples.

Chair Van Horn asked Mr. Mitry, Dr. Benhamida, Ms. Mikalson, and Mr. Gilmer if “complicated and traumatic loss” captures the idea they were looking for. They agreed. Mr. Mitry stated it could be if multiple, complex, or complicated losses with severe trauma is specified.

Chair Van Horn asked if the makers of the motion would consider this addition as a friendly amendment. Commissioners Poaster and Buck agreed.

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

The Commission adopts Staff’s rejections of public comments to Proposed Prevention and Early Intervention Regulations Section 3705 through 3740 as set forth in the, “Matrix of Public Comments with Staff’s Suggested Responses,” except as to Comments 6.05 and 36.07. The Commission adopts adding “traumatic loss (e.g. complicated, multiple, prolonged, severe)” to subparagraph (1) of subsection (c) of Section 3720.

- Motion carried, 11-0

Chair Van Horn thanked all those who provided comments to the PEI Regulations. He stated the comments resulted in valuable adjustments in the regulations. Some comments were rejected, but the commenters did a masterful job of putting this together and the MHSOAC staff did a masterful job of putting it in a digestible form.

GENERAL PUBLIC COMMENT

Ms. Torres suggested defining “severe persistent mental illness,” because Post Traumatic Stress Disorder (PTSD), trauma, and loss are included, but were not included in 2004 when it started. She stated her concern that the severe persistent mentally ill are being incarcerated and end up homeless; they are not being hospitalized, treated, or reached out to. Prevention and early intervention should be reaching out to them.

Mr. Czarnecki thanked the Commission for the work they did on the PEI Regulations and for organizing them in an easily-digestible manner and one that can be fully reviewed. He asked how staff arrived at that small county designation.

Chair Van Horn state the small county definition comes from the DOF. It is in regulations statewide and the Commission does not control it.

Jan McGourty, of NAMI Mendocino, stated Mendocino County is a very small county with a population of eighty-five thousand with no long-term county housing, no severe treatment centers, limited medical service with only one clinic that accepts Medicare clients, and a perpetual cycle of clients going from the emergency room, to the jail, to the streets, and back again.

She stated she was encouraged that the Commission accepted the innovative program by Inyo County. When there are no services, any service would be an innovation. She asked where the oversight is and what the consequences are when MHSA funding is coming into the county, but there does not seem to be any evidence of it.

Chair Van Horn stated the oversight in local counties is from the board of supervisors. The mental health advisory board or local mental health commission is their advisor. Oversight is provided by the voters. The role in Mendocino County for NAMI is to ensure that the right people get appointed to the local mental health commission, and that NAMI has a strong presence at board hearings, because that is where change takes place. While the Commission has oversight over the total system, it does not have much strength in individual counties. Counties have the strength locally. He stated the local boards and commissions need training and support from an organization of local mental health advisory boards to ensure that their voices are heard.

Mr. Gilmer asked about the fifteen-day public comment period and what the next steps were in the process.

Ms. Yeroshek stated an official fifteen-day notice will go out via the public LISTERV, mail, and email. There will not be a public hearing at the end of the fifteen days. At the October meeting, the Commission will repeat the structure for today's changes. They will hear public comments made on the changes, and vote whether or not to accept staff's recommended changes.

ACTION

6A: APPROVE CONTRACT WITH MENTAL HEALTH DATA ALLIANCE

Presenter:

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

Dr. Bradley gave a presentation to recommend action to give Interim Executive Director Sherri Gauger the authority to enter into a contract with Mental Health Data Alliance (MHDATA) for no more than \$327,313 to complete the scope of work and deliverables for the assessment of the classification of Full Service Partnerships (FSP) on a statewide level. The project will explore the feasibility of classifying FSPs in a meaningful and useful manner.

She reviewed the Commissions' commitment to evaluation, the Commissions' statutory role to evaluate California's public community-based mental health system, and the scope of work and deliverables.

Commissioner Questions and Discussion:

Chair Van Horn asked if the assessment includes "FSP Lite" and if it looks at levels of care within a full service spectrum. Dr. Bradley stated it does not include FSP Lite.

Commissioner Gordon asked about the MHDATA. Dr. Bradley stated the MHDATA is a familiar contractor for the Commission. Kate Cordell, the owner and founder, presented the

results of her statewide FSP analysis at last month's Commission meeting. She knows the Data Collection and Reporting System (DCR) that is used to provide the state with data on FSPs and has worked with the counties extensively on these programs.

Chair Van Horn stated this assessment does not take into consideration the work that the then-California Mental Health Directors Association (CMHDA), now California Behavioral Health Directors Association (CBHDA), has done around levels of FSP. As people have experienced recovery, they found they do not need that level of intensity, and are still having a full-service experience.

Dr. Bradley stated the University of California San Diego (UCSD) study will explore that issue. One of the final deliverables within that contract is going to be policy recommendations. The contractors at UCSD will specifically provide policy and practice recommendations on how to improve upon the current CSS services including Chair Van Horn's issue.

Within the scope of the MHDATA contract, they will look at FSPs in the way they are currently being implemented and defined. It is a possibility that the system could eventually be broadened to include other programs, but it is initially going to be focused on FSPs. That is how the contract with MHDATA is framed, but there could still be room for broadening it.

Chair Van Horn asked if the CBHDA has been involved in that discussion. Dr. Bradley stated the only way CBHDA would have been involved is within the development of the initial idea, when it was put forth within the MHSOAC Evaluation Master Plan adopted by the Commission last year.

Commissioner Keith asked about the timeline to complete the project. Dr. Bradley stated the MHDATA will have three fiscal years from now to complete it fully. MHDATA plans to begin work in October.

Commissioner Nelson asked if Kate Cordell has any staff and, if so, how many. Dr. Bradley stated MHDATA is a small nonprofit. She stated she has met at least three staff and Kate Cordell is in the process of hiring additional staff.

Commissioner Buck stated, as the former Chief Executive Officer (CEO) of an agency with multiple FSPs, he was looking forward to seeing how MHDATA structures this. He asked if MHDATA will look at the cost factors with FSPs. For instance, in some urban areas, the housing costs are very expensive and, in rural areas, there is a great loss of time and distance because of the geography of some of those counties.

Dr. Bradley stated the initial part of the start-up is to meet with people, and she asked Commissioner Buck to refer contacts to her so she can get some of their ideas incorporated into the project. She stated she had not considered Commissioner Buck's idea of evaluating the costs.

Commissioner Buck stated he understands the classification end. He asked if there will be evaluations on outcomes such as helping people find work, participating in education, reducing hospitalizations, and reducing homelessness.

Dr. Bradley stated including outcomes within the system is something else she had not thought about. She stated she envisions it being a large, web-based database where programs are categorized in different ways. This is a program that serves the type of population that potentially has specific outcomes, if that information can be obtained. The state currently has that information via the DCR, but the statewide data is necessary to do the latter piece.

Commissioner Buck offered to work with staff to make this come together.

Chair Van Horn asked if the MHDATA will be required to collaborate with the UCSD contract. Dr. Bradley stated they are already connected via a consultation contract.

Public Comment:

Ms. Hiramoto stated she has made the request in the past for a simple analysis of whether there are racial and ethnic disparities in the amount of service, consumers, and family members that are in these programs. She requested the information on where to obtain the material on the race/ethnicity breakdown so the REMHDCO can do a comparison.

Action: Commissioner Carrion made a motion, seconded by Vice Chair Pating, that:

The MHSOAC authorizes the executive director to execute a contract for no more than \$327,313 with Mental Health Data Alliance to complete the scope of work and deliverables for the assessment of the classification of Full Service Partnerships on a statewide level.

- Motion carried, 11-0

INFORMATIONAL

7A: PROPOSED INNOVATION (INN) REGULATIONS: PUBLIC HEARING

Presenter:

Filomena Yeroshek, MHSOAC Chief Counsel

Ms. Yeroshek stated this official public hearing is being held pursuant to the Administrative Procedures Act. Today is the end of the forty-five-day public comment period. Five o'clock today is the end of the written public comment period.

Public Comment:

Ms. Hiramoto commended staff on Section 3580, and stated she supports their breakdown of the demographic information that needs to be collected on innovations. She stated without changes, improvements cannot be made in reducing disparities. Data must be disaggregated in order to better serve communities.

She suggested that, in Section 3580.020 about the final innovative project report, it would be helpful to specify when programs begin and end.

She agreed, in Section 3930, with the requirement for meaningful stakeholder involvement, but hoped that there would be more work done on what constitutes meaningful stakeholder engagement.

On Section 3935(a), Ms. Hiramoto suggested that the stakeholder involvement specify that it must be comparable to the stakeholder involvement for the three-year expenditure plan or annual updates to ensure that it is comparable to the quality and the intensity for the other components.

Ms. Shilton stated she provided written comments with five key recommendations for clarifications of language and consistency of reporting requirements, based on what counties are required to report to the DHCS. She stated one of the key recommendations is related to Section 3910 about the definition of INN Projects. Proposed language has been provided in the written comments that she supports the language that allows counties across the state to fund INN Projects, even if they are funded in other counties, even if they are similar projects, as long as there is documentation that the approach is unique to that community or county.

Ivan Anderson recommended including Skype for Commission meetings.

Next Steps

Ms. Yeroshek stated staff will receive the public comments, review them, and then make recommendations. The comments will be provided verbatim with staff's recommendation of what to accept and what to reject. The public comments and staff recommendations are tentatively scheduled to be presented at the September meeting.

ACTION

8A: ADOPT REVISED PROCESS ON PRIORITIZATION CRITERIA

Presenter:

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

Dr. Renay Bradley, Research and Evaluation Director, stated, in March of 2013, the Commission adopted an MHSOAC Evaluation Master Plan. Within that plan is a prioritization process to be used annually to prioritize evaluation activities, and includes a set of criteria by which activities can be judged. The process was first used to determine activities for fiscal year (FY) 2013-14, and the MHSOAC Evaluation Committee and staff used the same process for FY 2014-15. The Committee voted to annually review the process to ensure it meets MHSOAC needs, and is currently considering the process to determine activities for FY 2015-16.

Committee members and staff take the yet-to-be-completed activities from the MHSOAC Evaluation Master Plan, completed evaluation reports, recommendations made by contractors, Committee members, and stakeholders for future evaluation ideas and activities, and use the original prioritization criteria to judge them.

Using the experience of working with the original prioritization criteria last year as a guide, the MHSOAC Evaluation Committee and staff revised and strengthened the criteria. In the original process that has been used for the past two years, all of the criteria were weighted equally, each criterion was rated on a three-point scale, and there was no "do not know" option, so if the rater was unsure how to rate an activity on a specific item, none of the other scores would count. In the revised process, three "yes/no" questions were added, more important criteria were weighted, each criterion is rated on a five-point scale, a "do not know" option was added, and cost, timeliness, and feasibility were deleted.

Dr. Bradley reviewed the sixteen criteria that will be used to establish evaluation activities for FY 2015-16.

Commissioner Questions:

Vice Chair Pating stated the Commission has approximately one million dollars to be spent on selected studies. The use of the prioritization criteria is an internal process of how the MHSOAC Evaluation Committee rates potential activities to make recommendations to the Commission.

Commissioner Wooton asked how the MHSOAC Evaluation Committee would choose the activity that should come first, and, if something else comes up of higher importance, how the Committee will make that determination.

Vice Chair Pating stated the ideas are held against and compared by the evaluation tool to determine the level of importance. Ideas can be rerated, and the Committee may combine ideas if there are multiple studies that seem to be pointing in the same direction. The goal is to determine the top four or five ideas to present to the Commission for approval.

Commissioner Wooton stated sometimes things are brought to the surface more than others, but stakeholders and consumers feel they are just as important.

Vice Chair Pating agreed and stated that is why he hopes people will participate in the process. He stated stakeholders are welcome to add input or join the MHSOAC Evaluation Committee.

Commissioner Carrion stated his concern about the ideas the Commission never gets to see because they may not have scored favorably. He noted that the first three items follow the Commission's Logic Model very concretely.

Commissioner Wooton suggested adding "culturally-focused" to the "wellness-, recovery- and resilience-focused" criteria. Dr. Bradley stated cultural competence is one of the MHSA values and is within the first of the three "yes/no" questions, but it could additionally be included in the list of criteria.

Commissioner Gordon asked how the MHSOAC Evaluation Committee understands the expectations of the Governor, the Legislature, or the general public if it is an internal process. It is important to understand how to make the programs better, but it is also important to report to the general public and the funders on the overall value of the enterprise. He asked how those entities understand the information the Commission is reporting, and how the Commission knows it has been successful in relaying the information.

Commissioner Carrion stated it is important to make a differentiation between the outcomes of the projects that have been funded and this prioritization process.

Dr. Bradley stated the other side of this is communications - what the Commission does with the evaluations once they are completed. One of the strategies for providing oversight is to communicate the impact of the Act. That comes at the end. She asked Commissioner Gordon if his concern is about the process for identifying what to do to begin with.

Commissioner Gordon stated the other part of communication is understanding if issues are being addressed that people consider are important to know about in the first place. He stated some organizations have focus groups with the public to find out what is important to stakeholders in different areas and what they want to know about.

Dr. Bradley suggested asking the MHSOAC Director of Communications to take part in this process.

Chair Van Horn stated the Commission hosts four community forums a year, which has a broader range of stakeholders across the State. There could be a question in those public forums about what stakeholders think the Commission should evaluate.

Commissioner Poaster stated Commissioners should have the ability to comment on how resources are prioritized in the coming year for evaluation. He suggested that the MHSOAC Evaluation Committee bring their recommendations to the Commission before beginning the Request for Proposal (RFP) process.

Public Comment:

Mr. Mity suggested including the impact and role of relationship status to determine potential for wellness or any level of risk for depression, anxiety, substance use, suicidal ideation, when considering evaluation activities.

Dr. Bradley stated Mr. Mity's evaluation idea will be brought before the Committee to be "thrown into the mix."

Mr. Gilmer stated, while the sixteen criteria are a good start, it highlights the lack of depth and disaggregation for reducing racial and ethnic disparities. It further exacerbates the fact that there is no concrete way to measure race, ethnicity, culture, or sexual orientation. He asked how disparities can be changed if this data is not measured. He suggested the involvement of a leadership team made up of subject matter experts from the California Reducing Disparities Project (CRDP) partners, the REMHDCO, the CMMC, and others to help develop a core set of values on how to measure behavior and new practices and help with future funding recommendations.

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

The MHSOAC approves the revised MHSOAC Evaluation Master Plan Prioritization Process Criteria with adding, “cultural competency” to criteria number 16.

- Motion carried, 11-0

ACTION

9A: POLICY AND PROCEDURES PAPER - HOW EVALUATION EFFORTS CAN CONTRIBUTE TO MHSOAC-ADOPTED OVERSIGHT AND ACCOUNTABILITY STRATEGIES: ENCOURAGING POSITIVE OUTCOMES ACROSS THE STATE

Presenter:

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

Chair Van Horn reminded members of the audience that this Policy Paper is before the Commission for a first read and there will be another chance to make additional comments during the second read.

Dr. Bradley stated the 2010 policy paper, titled, “Accountability Through Evaluative Efforts: Focusing on Oversight, Accountability, and Evaluation” needs to be updated. It was written at a time when the Commission was primarily focused on plan review and approval, not evaluation, and the Commission has already completed all evaluation efforts outlined in that plan.

In July 2011, the Commission adopted a Logic Model that outlines several oversight and accountability strategies, such as communicating the impact of the Act and influencing policy, and highlighting specific focus areas. The focus areas are the things that the counties are required to do.

In March 2013, the Commission adopted the MHSOAC Evaluation Master Plan and associated Implementation Plan.

In August 2013, the MHSOAC Evaluation Committee voted to revise the paper based on contextual considerations and the fact that the initial paper was written prior to statutory changes. The purpose of the revised paper is to provide the Commission with direction regarding its evaluation efforts, including how evaluation can contribute to the oversight and accountability strategies listed in the MHSOAC Logic Model and evaluation activities determined from the prioritization process.

The revised paper sets forth processes through which evaluation efforts can contribute to the MHSOAC Logic Model strategies and the focus areas within the model. Processes are intended to provide structure that will enable the Commission to use evaluation efforts to contribute to its oversight and accountability statutory role.

Dr. Bradley reviewed the MHSOAC evaluation goals and mission.

She emphasized the Commissions' commitment to evaluation, and stated evaluation efforts contribute to the seven adopted strategies from the MHSOAC Logic Model. This policy paper describes processes for how evaluation efforts can operationalize those strategies. Dr. Bradley reviewed the seven tasks for the Commission to focus on to achieve these goals:

- To track, monitor, and evaluate each of the focus areas
- To use results for quality improvement purposes
- To use results for compliance purposes
- To use results for communication purposes
- To improve likelihood that counties have resources to carry out evaluation
- To improve likelihood that the state has what it needs to carry out evaluation
- To routinely evaluate MHSOAC's performance in achieving goals

Commissioner Questions and Discussion:

Commissioner Gordon asked if the MHSOAC Logic Model is up to date.

Dr. Lee, the author of the MHSOAC Logic Model, stated there are two changes that need to be made to the MHSOAC Logic Model. She recommended adding "approval," because the Commission has the responsibility for approving Innovation Programs, and it is one of the oversight and accountability strategies. At the time the MHSOAC Logic Model was developed, it was after Assembly Bill (AB) 100 had passed and there was no statewide approval.

She agreed with Dr. Bradley in that evaluation is not just for the purpose of quality improvement, but evaluation relates to all of the strategies in the MHSOAC Logic Model. She also agreed with Commissioner Gordon in that looking at evaluation as primarily focusing on quality improvement gives less attention than it needs to informing policy and informing communication, particularly with regard to the public and the legislators. She stated focusing on the role of evaluation would encourage the Commission to look at what those entities want to know at the beginning in terms of selecting and prioritizing the evaluation strategies.

She reinforced Dr. Bradley's comment that the MHSOAC Logic Model is set up to be a structure that shows how the Commission leads to the outcomes in the Act, how the counties and implementers lead to the outcomes in the Act, and what the relationship is between them. She added that the MHSOAC Logic Model intentionally leaves the specific tasks blank with the idea that the Commission's work plans, priorities, Committee Charters, and everything the Commission does to fill in the specific tasks would be tied to those outcomes, and would help prioritize the outcomes at any given time.

Vice Chair Pating agreed that updating the MHSOAC Logic Model would provide a framework to ensure that the Commission applies its products in a way that would move Commission activities forward.

Commissioner Gordon suggested that the Commission adopt an updated version of the MHSOAC Logic Model and the revised policy paper simultaneously.

Chair Van Horn asked staff to make the minor adjustments to the MHSOAC Logic Model to be presented with the second read of the policy paper next month so this can be done as a package.

Public Comment:

Mr. Gilmer requested that his other comments be incorporated into this section.

GENERAL PUBLIC COMMENT

Ms. Hiramoto announced that REMHDCO's Assistant Director, Noemi Castro, will be leaving REMHDCO. She invited Commissioners to attend a reception after today's meeting at five o'clock. She stated Ms. Castro has brought a new level of quality and professionalism to REMHDCO and they are very sorry to see her leave. Ms. Hiramoto acknowledged Ms. Castro and her work in reducing disparities.

Ms. Castro thanked the Commission for all the dialogue and for receiving her input and allowing her to be an advocate in this platform, and stated it has been a pleasure and an honor to participate in Commission and Committee meetings. She invited Commissioners to attend the small gathering being held for her at the Capitol Garage at 15th and K at five o'clock. She stated she will begin employment on September 21st at the Tipping Point Community in San Francisco.

ADJOURN

There being no further business, the meeting was adjourned at 3:45 p.m.