

**COMMISSION MEETING MINUTES**  
**Thursday, July 26, 2007**

**I. Call to Order**

Vice Chair Gayle called the meeting to order and welcomed everyone. Vice Chair Gayle swore in new Commissioners Larry Poaster, Eduardo Vega, Larry Trujillo, and Beth Gould. Each new Commissioner provided a brief history of their background.

**II. Roll Call**

Present were Commissioners Wesley Chesbro, Paul Dobson, Linford Gayle, Beth Gould, Mary Hayashi, William Kolender, Kelvin Lee, Larry Poaster, Andrew Poat, Darlene Prettyman, Larry Trujillo, and Eduardo Vega.

Absent at roll call were: Commissioner Saul Feldman, Patrick Henning, Jr., David Pating, Darrell Steinberg

**III. Minutes Approval**

**MOTION:** Co-Chair Gayle asked for a motion to approve the June 2007 minutes. Commissioner Chesbro moved approval, seconded by Commissioner Poat . Motion carried unanimously.

**IV. Executive Director's Report**

Sheri Whitt, Acting Executive Director provided the following report:

- The MHSA Act creates 8 programs
- 5 permanent
- Community Services & Support
- CSS Innovation
- Prevention & Early Intervention
- PEI Innovation
- State Administration
- 3 temporary
- Local Planning
- Education & Training
- Capital Facilities & Information Technology
  - Programs operate on three year cycles (first cycle 4 ½ years)
- Community Services & Supports: The primary purpose is to provide services to children, TAY, adults and older adults that are developed in partnership with youth and their families, culturally competent, individualized to the strengths and needs of each child and their family, and consistent with the philosophy, principles and practices of the Recovery Vision for mental health consumers
- Funding formula is established by counties and the California Mental Health Directors Association

- Funding: 52.2% years 1-4, 71.25% years 5 and later
- Programs:
  - Statewide programs
  - Housing: \$1.5 billion total/20 years-construction, acquisition; \$800 million total/20 years-operating costs
  - Prudent Reserve
  - County Programs
  - County CSS plans
    - CSS Contract Amendments
    - CSS Implementation Progress Reports
- Housing
  1. Guidelines – no guidelines; application only
  2. Applications are still being worked on by DMH and CalFHA. The draft is not available for preview by the public or MHSOAC. The expected release date is August 1 or shortly thereafter. Once the application is ready, the funds will be released over the counter, which means whenever the counties are ready to apply they will be able to do so. There will be no application deadlines.
  3. Review – DMH has proposed a review process which includes receipt of comments from OAC. The OAC has received feedback from the California Network for Mental Health Clients regarding areas to focus on in our review of housing applications and a report will be given in September.
  4. Evaluation for effectiveness – For tenants who are enrolled in a Full Service Partnership, outcomes reporting requirements will be consistent with those that were established by the Department for individuals who are enrolled in the CSS category of the Full Service Partnership. DMH and CMHDA are working on finalizing outcome reporting requirements for non-Full Service Partnership tenants.
  5. Project oversight – CalFHA will have the ongoing oversight for all housing aspect related items related to this and DMH and County mental health departments will have primary oversight roles for monitoring quality control.
  6. Ongoing implementation workgroup – There will be an ongoing implementation workgroup to ensure that the application process is accessible and effective and to support existing projects as issues emerge.
  7. Regulations are in the process of being developed.
- CSS Plans
  - CSS contract amendments (expansion funding) have been received from 8 counties.
  - CSS Implementation Progress Reports – These reports were due June 30<sup>th</sup>, however extensions were available upon request by the county and the new due date was August 31. A summary is forthcoming from DMH.
  - Regulations – The OAC submitted comments to DMH during the public hearing process and requested changes. No outcome to report.
- CSS Innovation
  - Purpose is to increase access to underserved groups, increase the quality of services, including better outcomes, promote interagency collaboration, and increase access to services.
  - Funding formula is established by counties and CMHDA.

- Five percent of the total funding for each county mental health program for CSS is allotted to innovative ideas.
- Programs:
  - County submits plans
  - DMH reviews
  - OAC budget approval authority
  - Innovation Status
  - Guidelines are not written until DMH receives direction/principles from the OAC. The OAC Innovation Paper is being presented at today's meeting. Timelines will be established once direction is received from OAC
  - Typically regulations are written by DMH as they write the guidelines with the intent to have them in effect before the money flows.
  - In terms of evaluation for effectiveness, OAC will want to provide guidance regarding their expectations.
  - Prevention & Early Intervention
    - The purpose is to prevent mental illnesses from becoming severe and disabling, improving timely access to services for underserved populations, providing outreach to recognize early signs, access and linkage, reduction in stigma and discrimination.
    - The funding formula is developed by the counties and CMHDA
    - Funding is 19 percent each year.
    - The state administered programs are: suicide prevention; suicide prevention strategic planning; stigma and discrimination reduction; training and capacity building; and ethnic and cultural specific programs
    - The county administered programs are in the area of guidelines, review and comment (which is the role of DMH); and budget approval (which is the role of OAC)
    - Prevention & Early Intervention Status
    - Proposed guidelines will be discussed at today's meeting
    - Regulations will be discussed at the future meeting. Per regulations process, there will be a public comment period before they become permanent and the public and the OAC may offer comments regarding requested changes to the regulations.
    - Evaluation for effectiveness will be discussed this afternoon.
    - Prevention & Early Intervention Innovation
      - The purpose is to increase access to underserved groups, to increase the quality of services, including better outcomes, promote interagency collaboration, and increase access to services
      - Funding formula is established by counties and CMHDA
      - Funding is 5 percent of total funding for each county mental health program for PEI
      - Status
      - Guidelines are not written until DMH receives direction/principles from the OAC. The OAC Innovation Paper is being presented today. Timelines established once direction received from the OAC.
      - State Administration
        - The purpose is to cover the state costs of program administration
        - There is no funding formula for the state administration funds. The maximum amount allowable is 5 percent. Requests must be submitted through the state budget process. The state budget sets the limits within the total amount available.
  - The surplus returns to the general MHSA fund to be redistributed to components when it is no longer available for state expenditure. Unbudgeted funds are returned at the end of the fiscal year. Budgeted but unexpended funds are returned two years later.
- Local Planning

- The purpose is funding to cover annual planning costs and it includes funds to assist consumers, family members and other stakeholders to participate in the planning process.
- DMH makes the proposal regarding the funding formula.
- Funding should not exceed 5 percent of the total of annual revenues received for the fund.
- In terms of programs it is designed for county administered plan development with intensive stakeholder input
- Capital Facilities & Information Technology
- The purpose is for first cycle only funding to build capital capacity, treatment and service facilities and program administration
- The funding formula is established via DMH proposal
- Funding is 10 percent for the first cycle only
- The programs are facilities and technology needs that are identified to support CSS & PEI plans and could include things, such as, Electronic Health Records
- The proposed guidelines are drafted and going through final review
- Regulations are currently being drafted based on proposed guidelines.
- In regards to evaluation for effectiveness more discussion is needed in this area.
- Education & Training
- The purpose is for first cycle only funding to build human resource capacity for program expansion.
- The funding formula is established by DMH and the county.
- Funding is for 10 percent for the first cycle only
- The projects will support CSS and PEI plans
- Status
- The proposed guidelines are out now for the planning and early implementation funding. The balance of requirements will be out soon.
- There have been 19 requests from counties for planning funding and 15 have been reviewed.
- The regulations process will unfold as described.
- More work is needed in the area of evaluation for effectiveness.
- Funds
- In terms of distribution formula, public reporting strategies, and prudent reserve strategies will be discussed in DMH's report.
- Technical Resource Groups
- Measurements and Outcomes Technical Resource Group, Cultural and Linguistic Competency Technical Resource Group, and the Client and Family Technical Resource Group, will all report at tomorrow's meeting.
- The Mental Health Financing Technical Resource Group was adopted at the June meeting and will begin once staff has been hired to staff it.
- Staffing
- Executive Director Search: A recruitment flier has been developed and widely distributed by both DMH and the OAC. Based on the applicant pool, a decision will be made by DMH/OAC about hiring an executive search firm. The application deadline is August 17, 2007.
- Communications Director: Interviews and reference checks have been completed and an offer was extended. Staff is waiting to hear if that offer has been accepted.
- Mental Health Program Supervisor: An offer was made and accepted and Derrick Green will be joining the OAC as the new Plan Review Mental Health Program Supervisor.
- Office Technician: An offer was made and accepted and Danial Leahy will be joining the staff on July 30, 2007.
- Staff Mental Health Specialist: Michelle Woods is leaving her position and staff will be looking to fill this position.

- Associate Mental Health Specialist is in the process of being hired.
- Other positions: DMH helped bring Tim Farley on board to help move staffing forward.
- Follow-up to the June OAC Meeting
- Vice-Chair Gayle asked for an update regarding the Native American Mental Health Services. A telephone survey was conducted to get a more in-depth understanding and a copy of the survey and an executive summary of the results are included in the Commission binder.
- Another issue was regarding client participation and how does the OAC support this. OAC contracts with a client network in the amount of \$33,000 to help support client participation and MHSA activity.
- The issue of client grievance process was raised. Ms. Whitt has been in communication with Laurel Mildred, who is the Executive Director for the Client Network. The Executive Committee is looking at this issue and will bring feedback to OAC.
- The two-tier mental health system issue was also brought up at the last meeting. The issue is a system whereby those individuals who are being served via MHSA programs are having access to a level of treatment and service that is not available to other who are already in the system. Ms. Whitt informed the Commission that meetings have occurred with Carol Hood, Rose King, and many others to discuss this issue further. There were particular actions that were proposed at the meeting: (1) CCMHA and the Mental Health Directors Association will work to describe the transition process for CSS to serve underserved and to integrate MHSA with the current system; (2) OAC will be discussing technical amendments to the PEI principles language so that the priority populations identified as first break and trauma victims do not exclude people who seek help in the public health system; (3) participants at the meeting were to share notes of this meeting with others; (4) the possibility of holding informal brown bag lunch discussions is being explored; and (5) on July 13<sup>th</sup> Mr. Selix prepared a paper in response to Rose King's memo, entitled "Can the Mental Health Services Act Serve Everyone and Give them Everything".

### **Commissioner Questions/Comments**

Commissioner Lee asked if there is a formal process for the Commission to be involved in the interviewing and hiring process. Ms. Whitt said she will bring more specific information back to the Commission once she clarifies the process with Dr. Mayberg.

Commissioner Poat said during the closed session at the last meeting a Committee of Commissioners were named to participate in this process. Commissioner Chesbro said what needs to be worked out between the Department and the Commission is the statute which essentially leaves the formal decision in the hands of the Director of Mental Health and the Commission's need to have an executive director who is accountable and responsive to the Commission.

Commissioner Prettyman said she would like to speak to the grievance process. She understands that the Client Network is developing this process and she asked that they include family in the grievance process because there are many persons who are not able to fill out their grievance.

Commissioner Gayle said the Client Network has \$33,000 in their budget to help consumers with travel expenses to meetings, etc. He asked for some clarity on how the selection is made. He does not want a division between consumers and family members. Ms. Whitt said she will do some research on this issue and bring more information back at the September's meeting.

### **V. Department of Mental Health Report**

Carol Hood, Deputy, Department of Mental Health provided the following report:

- The goal for MHSA financing is to present easily understood and current information using a consistent format about the status of MHSA funding through regular status reports to the Oversight and Accountability Commission. She added that this information will be on DMH's website and regular updates will be made.
- The Department wants to only rely on the cash that it actually has on hand. It is estimated that MHSA will receive 1.76% of the tax revenues but this is a guess. Once the revenues are received a calculation will be made upon the actual income tax returns.
- Quarterly deposits are received on interest income
- Community Services and Supports – July 2007
- Dedicated funding began 07/05
- Total deposits FY 05/06 and FY 06/07: \$985 million
- Distribution total: \$653 million
- Commitments: \$430 million
- Balance (\$98 million)
- Workforce Education and Training – July 2007
- Dedicated funding began 1/05
- Total deposits FY 05/05 through FY 06/07: \$303 million
- Distributions total: \$ 0
- Commitments: \$200 million
- County Planning Estimates: \$100 million
- State administered programs: \$100 million
- Balance: \$103 million
- State Administration – July 2007
- Dedicated funding began 1/05 – maximum of 5%, but operating at levels well below 5% for state administration.
- Balance: \$64 million. As soon as a budget year ends, any money that is unbudgeted that was in the 5% will immediately be redistributed to the components so it can be dedicated to services and money that was dedicated to the Department but unspent. The Department has two years to spend it. When it no longer is available to the Department it will be redistributed.
- Current DMH MHSA Priorities
- The Department commissioned a group to look at the State's stakeholder process. The report is completed. The purpose of the report was to understand what the Department does well so it can be preserved in the future, and what needs to be done for further development. This report is currently being printed and will be available shortly.
- In Community Services and Supports there is \$115 million additional money that has been made available to counties. The total annual amount now is \$450 million.
- Reviewing implementation progress reports; a group has been commissioned to help develop a summary of this.
- Assisting counties with implementation.
- In the Housing Program it is expected that the application will be released on August 6, and technical assistance to counties and developers will be provided.
- In regards to Education and Training, the proposed guidelines were released this week. Counties can now submit plans for the \$100 million.

- Capital Facilities and Technological Needs: The primary issue that is remaining before they release the guidelines is whether capital facilities funding can be used for private entities.
- Prevention and Early Intervention: The Department is getting input from the Commission and stakeholders to analyze, complete proposed guidelines, and continue to work on strategies for evaluation. In addition, the Department is working on developing the suicide prevention strategic plan.
- The integrated plan and annual update are at the very early stages of beginning conceptualization.
- Fiscal policy re-evaluation: The Department found that some of its processes are phenomenally complex and staff intensive. There will be some substantial adjustments that are being made in order to simplify the process and still bring sufficient information to maintain accountability.
- The Department is looking at a re-organization.
- There has been a major effort to re-design the performance contract. Substantial progress has been made on the sub-grant process, which is used both by EDD and by Social Services for the CalWorks Program.
- Some counties remain without contracts. They have been notified that no further payments will be made unless they submit their signed contract.
- Regulations: Completing the process of transitioning from the overall package from Emergency Regulation to permanent. The package must be completed by December 31, 2007.

### **Commissioner Questions/Comments**

Commissioner Lee asked about the distribution chart Ms. Hood showed. He asked if OAC is under state administration. She said, yes, OAC is part of the 5 %. Commissioner Lee asked how the OAC budget is operational; what was its proposed budgets; how much was spent from its proposed budget; and what was the return. He mentioned that if there were not a significant amount of dollars used then how can it be corrected in order to get sufficient staffing. Ms. Hood said she will work with Ms. Whitt as to whether OAC would like this as part of the Department's report or whether it should be a part of the Commission's report.

Commissioner Vega asked what the process would be in determining when the unexpended funds at the state level will be redistributed. Ms. Hood said the two scenarios that the Department is currently researching is whether all of the money goes to Community Services and Supports or if it should be distributed to all of the components.

Commissioner Chesbro asked if the state's budget impasse is affecting the expenditure at the local level. Ms. Hood said there is still money flowing into the account and the Department can pay its bills to the counties for the MHSA. However, state administration is tied to the budget and so the 5% will not flow until there is a budget.

### **VI. Innovation Committee Report**

Deborah Lee, Consultant provided the following report:

- Commissioner Henry wanted the work of the Innovation Committee to: (1) result in a product that was simple, clear and short; (2) that the Committee come to agreement as much as possible; and (3) that the benefits of innovation reaches as many people in the state as possible.

- One of the greatest accomplishments thus far of the MHSA is the work of this Committee. The Committee used diversity as a way of learning from one another.
- Areas of focus include the priorities, which was taken from the Mental Health Services Act, and the principles, where the Committee is recommending that all principles be reflected in innovation programs.
- Scope is where most of the flexibility occurs.
- The definition of innovation that the Committee is proposing is a mixture of flexibility and focus.
- Four priorities are listed in the MHSA for innovation: (1) to increase access to underserved groups; (2) increase the quality of services, including better outcomes; (3) promote interagency collaboration; and (4) increase access to services. The Committee is recommending that these constitute the priorities for innovative programs and that all innovative programs select at least one of these to be its primary focus.
- The Committee hopes that through this approach all of the priorities will be addressed but that each county is not required to choose more than one priority.
- It is expected that while a county may choose one of the priorities as the primary, the other three would also be reflected in the program through the principles.
- She noted that one of the four priorities refers to increased access to underserved groups. Underserved groups are also referred to in the principles. One area where the Committee did not come to agreement, was whether or not it should specify a definition of underserved, or whether that decision should be left to the counties. The Committee present the following options to the Commission for its consideration:
  - The definition of “underserved” in the first round of Innovation funding should focus on four of the historically underserved groups: African Americans, Asian Americans/Pacific Islanders, Latinos and Native Americans;
  - OR
  - The definition of “underserved” should be determined by each county through its representative stakeholder process, to reflect the county’s needs, priorities and history.

It was pointed out that in the Legislation it is clear that the funding for innovation derives from a percentage of the funding for Community Services and Supports and for Prevention. The Innovation Committee is suggesting that despite the fact that the funding derives from these sources, that the priorities that have been defined for CSS and Prevention should not create a context for the decisions about the priorities for innovation. These decisions should be made independently.

- The key part of the definition of Innovation is” “. . . novel, creative, ingenious mental health approaches developed within communities in ways that are inclusive and representative, especially of unserved, underserved, and inappropriately served individuals. Innovation promotes recovery and resilience, reduces disparities in mental health services and outcomes and leads to learning that advances mental health in California in the directions articulated by the MHSA. Merely addressing an unmet need is not sufficient for innovation funding. Further, and by their very nature, not all innovations will be successful.”
- Whenever the term “individuals” is used the assumption is that it is to be representative of the community, including people who are unserved, underserved, and inappropriately served by the mental health system.
- When the term “services” is used, it is assumed that these are services that are chosen voluntarily and that they include Prevention and Early Intervention.

- Scope of Innovation: Innovation can be something that is brand new or it can be something that has been done elsewhere and is new for that community, but has changed or transformed in some way for that community. Or it can be something that has been done very successfully in non-mental health context but has not been applied to mental health.
- The scope is broad in order to be available for individuals, families, and caregivers across all ages; to include a variety of levels of intervention; and that it was not limited to programs.
- Principles and Example Criteria:
  - a) Principle A: It is the intention that each innovation would reflect all the principles.
  - b) Principle B: The stakeholder process was discussed, as well as a grass roots development process, and was deeply the cornerstone of the work of the Innovation Committee. It should be a process that evolves from community. The Committee felt it was very important to include people from grass roots community organizations, service providers, etc. who in certain cases are able to speak on behalf of the communities they serve.
  - c) Principle C: The intention of this principle is to state that the innovation will work and will be successful in leading to recovery and increased resilience and health. The reason it states “high potential for” rather than creates, is again to acknowledge that innovation is taking risks and we do not know for sure if it is going to be successful, but the intention is that it will lead to recovery, resilience, and health.

Commissioner Chesbro said his concern with this language is that it could be read to discourage funding things that are less proven. She said the intention is that it is hoped that the innovation will, in fact, lead to recovery, resilience, and health. You also want to allow for the possibility that it will not be successful. The Committee looked for language that suggested this was the intention without locking in the guarantee.

- d) Principle D: Cultural competency and capacity to reduce disparities in mental health services and outcomes was extremely important to the Committee.
- e) Principle E: Where it states, “initiate support and expand collaboration in linkages, especially connections with systems, etc. not previously defined as mental health ...” She said in reading this today, that this language is not quite strong enough, because what the Committee actually meant was not just linkages, but also that those places would be places where the actual innovation could take place.
- f) Principle F: It is not just that there should be evaluation, but that the evaluation in and of itself should be innovative. It should reflect the values and involvement of the people who are being served.
- g) Principle G: The plan to communicate successes and build on lessons learned, clearly if your priority is learning, you need to have a way to communicate that learning.
- h) Principle H: Leveraging resources to maximize impact.
- i) Principle I: Proposed innovation is time-limited; it is not an innovation forever. It is an innovation, but at some point it either becomes an idea that did not work out, or an idea that is transforming, or a practice that

you want to be part of your mental health system. The Committee wanted a sense of how it would transform beyond innovation.

- Other Key Recommendations:
  - a) Innovation Plan Requirements should be concise and that the review process will be simple and straight-forward without impairing or short-circuiting the input of stakeholders.
  - b) Nothing in these recommendations is intended to usurp or contradict existing practices to protect and secure the well-being of individuals comes from human subject reviews for research and the need to make sure that the well-being of individuals is protected.
  - c) There is a relatively small amount of funding for innovation. There has been interest on a part of a number of people, including members of the Committee, in finding ways to focus some of the funding. Again, the polarity where there is value on both sides is, on the one hand, you want to make sure that all communities have benefits of innovation and you want to maximize the flexibility of individual communities to define their own priorities. On the other hand, you do not want to dissipate the funding in way that you do not have impact.

The Innovation Committee discussed two possibilities for additional focus: pooling funds for statewide or regional programs, which would require agreement of counties, or focusing on one or more priority goals or topics. The Committee acknowledged and affirmed competing values: maximizing the potential impact of limited funds through focus versus supporting local communities to determine their own priorities.

### **Commissioner Questions/Comments**

Commissioner Lee acknowledged Deborah Lee for all her efforts in making this document happen.

Commissioner Dobson asked about the divergence of opinion on the underserved communities. There was testimony given at the last meeting that there are traditionally underserved communities, one of which includes the Gay, Bi-sexual but he noted that they are not in this group. Ms. Lee confirmed that they are not but could be added. Commissioner Dobson said the four recommended groups could be priorities, but leave the counties to design a program because all counties are different and the underserved will not be the same in all counties. It seems to him that there must be a way to put the two concepts together in one rule.

Commissioner Chesbro said he sees the merits of both sides of the argument and asked if there is some way to integrate both points. There is value to both sides of the discussion relative to the accuracy of what is the significant underserved population in a particular county, and on the other hand whether or not there is a significant underserved population that simply has not been responded to in that county because they are not visible enough.

Commissioner Prettyman said she is concerned with the definition of the underserved. There is another population, the severe mentally ill that are housed in board and cares and IMDs, and they do not get services. She hopes that this population is not forgotten.

Commissioner Vega said he believes that there is an option that is in the language, which is to combine the language recommending traditionally underserved and also allowing counties to identify what populations are underserved within their plan as their target. Ms. Lee said the Committee, in making their two recommendations, had one intention; that everyone who was unserved and underserved needed to be served in innovative ways. The question the Committee

had was, with limited funding and the data available, whether or not in the first round, the Commission should start with assessing the particular groups and make those the top priority versus having the county determine what the priority is in the first round for underserved.

### **Public Comment**

**Delphine Brody**, with the California Network of Mental Health Clients, said the Network as a whole has not had a chance to respond to the Innovation Paper so her comments are those of Sally Zinman and herself. She is pleased to see the recovery and resiliency values in many of the recommendations and that mental health services under the innovations component are defined as services that are chosen voluntarily.

She is also happy to see Principles B, proposed innovations are developed at the grass roots level with inclusive participation of potential and actual service users, their families and caregivers, and service providers and other representatives; Principle C, proposed innovations program has high potential for promoting recovery and increased resilience and health; and Principle D, that innovative programs demonstrate cultural competency and capacity to reduce disparities in mental health services and outcomes.

The Network sees value in both the statewide and local approaches and peer run services and crisis residential models are two models it would like to see, particularly the peer run crisis respite center that exists in New England.

Commissioner Chesbro requested that the Network, and all public speakers, provide their comments in writing.

**Ralph Nelson** said he is speaking as a resident from Tulare County, a rural county. He believes the Innovation Resource Paper was very good. However, he suggested that the underserved definition on page 2 should be determined by the county and by their focus groups' findings. For example, many rural counties have many geographically isolated consumers of all ethnicities and races are geographically isolated consumers and include Caucasians. The county should have the ability to look at what their needs and services are and then take a look at who the underserved are.

**Ann Arneill-Py**, with the California Mental Health Planning Council, commended the Committee for an excellent job fully elaborated program consistent with the goals of the MHSA. The Council would like to support the Innovation's Committee recommendation that the source of the funds, CSS and PEI component, should not define or limit the innovation programs and that the innovation funding priorities scope and principles and criteria should be independent of those requirements.

Regarding the definition of innovative programs, the first element of the definition does say that innovative programs should be novel, creative, or ingenious mental health approaches. This may be difficult to operationalize for each county. The "Scope of Innovation" provides a clear definition that would be easier to operationalize and the Council recommends that this be used as the definition.

Regarding Section 5, Principles and Criteria: Meeting all of the principles would be a high bar for all innovative programs to meet. The Council recommends that a proposal be able to explain why it might not meet one of the principles and still have the possibility to be approved.

Regarding the definition of the underserved: The Council recommends that the definition for the four historical groups be expanded to include LBGTQ.

The Council recommends including both aspects of recommending traditionally underserved and also allowing counties to identify what populations are underserved within their plan as aspects of the definition.

**Ken Epstein** said he sat on the Innovation Committee. He asked the Commission to consider two things: (1) funding not be distributed just equally to every county but that the principles and practices in the Innovation Resource Paper are looked at and a review committee be established to look at these practices can truly be innovative and funded properly; (2) sustain a permanent group of people, stakeholders, to look at the conceptual conversation.

He asked that this not be considered just a funding source because it is principally an opportunity to alter and change the system of care. The way this can be done is to establish a full time committee of people who are thinking conceptually about innovation.

**Charles Dempsey** said he served on the Innovation Committee and he is the officer in charge of the LAPD Mental Health Response in the City of Los Angeles. The processes of the Innovation Committee have been opened up to a varied group of stakeholders. Innovation is a seed of change. If innovation is treated just as a funding source, the opportunity will be lost to affect transformation of the system. Innovation requires that we look outside of what we normally see as mental health services. Let's continue to move forward and do not let this evaporate into the rest of the programs.

Commissioner Dobson clarified his comment that he believes the Innovation Committee needs to focus on the statutory base to increase access to underserved groups. Empirically the groups listed by the Innovation Committee are underserved groups and should be included in the priorities but he would like to see included the idea that counties don't have to design an entire program around a group where they do not have, in their county, the listed priorities.

Ms. Prettyman would like the Innovation Committee to try and find some way to address both the underserved group and the underserved persons. Crisis residential centers have been very effective in keeping people out of jails and hospitals.

Commissioner Gould asked that the new Commission members have a chance to read the Innovation Resource Paper, as well as an orientation, and then they can comment. Commissioner Prettyman suggested that perhaps someone who served on the Innovation Committee could be assigned as a mentor to the new Commission members. Ms. Lee will follow-up on this suggestion.

Vice Chair Gayle requested that the definition of underserved be put on agenda for the next meeting.

Commissioner Vega would like to see language in the Innovation Resource Paper to include peer support programs and client driven programs.

(Tape was changed and picked up as follows)

Commissioner Poat would like the Innovation Committee to address the distribution of the funds.

## **VII. Co-Occurring Disorders Report**

Rusty Selix, Executive Director of the California Council Community Mental Health Agencies (CCCMHA), recognized experts Dr. Gary Jaeger, Dr. Rod Shaner, and Judge Steven Manley. Mr. Selix provided the following report:

- Two of the fundamental premises of the Act are that recovery focus is to be whatever it takes and to acknowledge that supportive housing and co-occurring disorders treatment is one of the priority areas. Secondly, services are to be provided in an integrated manner. When these premises are applied it challenges the assumptions of the existing system.
- Key findings are:
- It is estimated that half of the people who have a substance abuse condition also has a co-occurring psychiatric disorder
- You cannot have successful treatment unless it is done in an integrated manner.
- The implications of not providing appropriate care in this area are that it has a high cost. Kaiser Permanente provides substance abuse treatment because they recognize that it pays for itself very rapidly in offsetting savings elsewhere in health care. They have data that backs this finding up.
- This particular population is over represented in the criminal justice and society is paying an enormous price for not treating.
- Experts suggest that the following needs to be done within the MHSA:
- Make sure there is integrated care for everyone who needs it
- There should be priority in training and education funding to co-train physicians, mental health professionals, the criminal justice system, and anyone dealing with co-occurring disorders.
- Housing is one of the biggest problems because there are a number of housing programs that will not take people with a substance abuse disorder or that they have to be clean and sober before they can be accepted. There must be housing for this population.
- There must be coordination among the many agencies involved to address the funding and provision and service.
- Combining resources from multiple funding sources where possible
- The Department of Corrections Rehabilitation services, particularly for parolees being returned to society needs to be in place. SBA51 is moving and it looks promising that it might be enacted.
- As people have relapses there needs to be the ability for a Mental Health Court to review it so people don't automatically go back into prison when there is the slightest problem.
- Make sure this is no "wrong door" and wherever an individual starts services both types of care are available.
- There needs to be some work done between the Commission and the Department to move forward with this and it is suggested a task force be implemented.
- It is recommended to have a multi-departmental task force to develop recommendations to OAC and to the Legislature.

Judge Manley, from Santa Clara County, provided the following information:

- When physicians and judges come together because they observe what they are trying to do is not working because it is mission the integration that Mr. Selix spoke of, then something needs to be done now.
- Proposition 36 prohibits the expenditure of any funding for mental health services for substance abusers, and Proposition 63 provides this service but it does not take place at the county level. He talks to many judges across the state that see defendants everyday who are not getting integrated services. This must change. He asked the Commission to do whatever it can to make sure that plans are not approved from counties unless they provide for these integrated services.
- The Courts are known as a punishment model and he is trying to change this to a treatment model for those who need treatment, specifically the mentally ill. The two departments, Drugs & Alcohol and Mental Health, must work together to assist in this matter because otherwise there is nothing the Courts can do to try and find treatment for the mentally ill.
- He urged the Commission to accept the report and move forward with the recommendations.

## **Public Comment**

**Dr. Gary Jaeger**, a recent member of the Commission who worked on the issue of co-occurring disorders, is here today representing the California Society of Addiction Medicine. Additionally, he is providing testimony as a client and a member of the family extensively and profoundly affected by these two illnesses. This issue underpins all of the Commission's work; the homeless issue cannot be solved without addressing this issue; the revolving door in the criminal justice system cannot be solved without addressing this issue; this issue profoundly affects the work of PEI; suicide prevention with attention to both of these issues will not be successful; and the education and training must be available. This is not just a public mental health issue, but involves the issue of insured persons as well. The lack of willingness among insurers to provide for appropriate care leads to failure. Failure leads to public welfare. Dr. Jaeger urged the Commission to look at this document as a baseline underpinning to all the work that faces it in the coming years.

**Roderick Shaner**, an addiction psychiatrist and a mental health systems administrator, said he is speaking on behalf of the California Psychiatric Association in support of this report. There is a great body of evidence that suggests that mental health services are simply ineffective for individuals with co-occurring substance abuse unless those services are coupled with integrated treatments for the substance abuse.

The report accurately identifies the challenges to the development of adequate programs to treat COD. There must be standards for integrated COD programs. Treatment standards, including staffing standards must be required for programs in order to ensure high quality and effective Services. Finally, the report makes a series of important recommendations. It suggests that MHSA plans for COD services include several critical components. The demonstration of coordination of resources that are shared among agencies to treat individuals with COD; that there be standards for integrated COD programs; and that special attention be paid to individuals needing treatment within correctional systems and after they are released.

CPA believes that the MHSA planning process must ensure the existence of comprehensive and coordinated COD programs that are funded through all appropriate revenue streams. CPA will work hard to support the Commission's role to improve mental health and substance abuse services for the people of California.

## **Commissioner Questions/Comments**

Commissioner Chesbro asked Dr. Jaeger if built into the comprehensive substance abuse service definition that there is a sufficient level of treatment. Dr. Jaeger said that this is the intention. It is meant to meet clients and families where they are, identify their needs, and to address their disease across the range of severity of mental health illness and dramatically across the range of substance abuse illnesses. For some it will require periods of residential care, as well as extensive care over months of time and for others it may require nothing more than a brief intervention. Dr. Jaeger said it is his belief that this Commission will have to play a major role in moving along bills that are in the House and Senate regarding this issue.

Commissioner Dobson asked if there were any programs for probationers. Judge Manley said there are programs at the local level. This is why it is so important that both the Drug & Alcohol Department and Mental Health Department work together. Parolees should be placed under the supervision of a judge in a different system outside the Board of Parole Hearings system.

Mr. Selix said the probationers and the people who are not yet in the criminal justice system are the Prop 63 targets. This part of the population will be covered through the Act but it requires the coordination that Judge Manley mentioned.

## **Public Comment**

**Robert Reid** said he will be speaking today on behalf of the elderly people, many of whom are shut ins. There are only two programs for the elderly in Orange County because there are not enough funds. When the Commission allotted 51% or more of the funds to be spent on 0-25 years of age it left little for the elderly. The highest rate of suicide occurs in males 65 years and older.

**Shelley Levin**, representing Telecare Corporation, commended the State and the OAC on the inclusion of specific guidelines for programs for early onset of psychotic disorders on the PEI guidelines. She offered, as a resource, a literature review on early intervention in psychosis.

**Judy Adams** said she is speaking as a family member and client. She commended the Commission on their fine work and that they recognize the split between family members and clients. Her county is trying to change all mental health services and she understands that more integration is needed so there is an equal opportunity for everyone. Her concern is that when you try to integrate for the better of all the essence will be lost. If there is true change throughout the counties in all services it will have to be monitored.

**Ken Epstein** urged the Commission to spend some time with the Co-Occurring Disorder experts who produced the draft document because he worries that the Commission will not afford enough time to understand the document before a decision is made.

**Delphine Brody**, with the California Network of Mental Health Clients, said she will e-mail her formal comments to Ms. Whitt. The Network agrees that it is true that an integrated service model is needed that includes services for mental health and substance abuse. The Network would like to see more focus on harm reduction, trauma informed services, and peer-run services. The Network disagrees that the basis for criminalization is necessarily a lack of treatment, because she sees other reasons why users of non-prescription drugs are criminalized. Mental health clients are criminalized in the area of discrimination and stigma and not just untreated conditions. Also, people with co-occurring disorders are disproportionately represented in the criminal justice system, yet the Network is not sold on the particular solution involving mental health courts. The Network would like to have a seat at the table in the design and implementation of any future mental health courts. There needs to be a harm reduction focus in treatments for people with dual diagnoses and it should include peer-run services, support groups, housing, etc.

**Dede Ranahan**, Mental Health Service Act Policy Coordinator for NAMI California, reiterated the underserved issue. This terminology is becoming problematic because everyone is feeling underserved. When you target populations as being “the underserved” then other people are felt left out. She said if there is any way to come up with terminology that does not imply that the other people who are not in those targeted populations are fully served.

**Zula Reeves** said that those who have never been served are not in the same category as those who have been. There are many people on the street who have never received any care whatsoever. She has been able to, with the funding, get them housing, jobs, and get them off the street but the funding is needed. There still needs to be more people of color on the Commission.

**Alisa Solomon**, with the L.A. County Department of Mental Health, Division of empowerment and advocacy, shared her vision that one day forced hospitalization will not be needed because everybody of every ethnic group and culture will get treatment as needed and that families will not be ashamed to bring in their members; that parents feel free to bring in their children when early signs start. She is hoping that the Commission will work towards her vision.

## VIII. Prevention and Early Intervention

Ms. Whitt said the current language is worded in such a way that it sounds as if you can only get help if you don't ask for it. In order to clarify that anyone who asks for help can have access to it the following amendment was presented:

- Technical amendments to MHSOAC 1/07 PEI Principles Document – Trauma Exposed
  - Proposed technical amendment: “Those who are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.”

**MOTION:** Commissioner Poat moved approval, seconded by Commissioner Dobson to approve the proposed technical amendment as presented. Motion carried with 2 abstentions.

- Technical amendments to MHSOAC 1/07 PEI Principles Document – Individuals experiencing onset of serious psychiatric illness
  - Proposed technical amendment: “Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.”

**MOTION:** Commissioner Lee moved approval, seconded by Commissioner Chesbro to approve the proposed technical amendment as presented. Motion carried with 1 abstention.

Ms. Whitt said she had a clarifying question to the MHSOAC 1/07 PEI Principles Document. At the Commission's June meeting they adopted the following wording: “Prevention and early intervention priority populations will include **children and youth at risk of first, or any, contact with any part of the juvenile justice system, and who also have signs of behavioral and emotional problems.**”

Ms. Whitt asked the Commission if this population includes children and youth who have had no prior contact with the juvenile justice system but are at risk for such contact (staff believes the answer is yes); does it also include children and youth who have had prior contact first or multiple times with the juvenile justice system but are not currently in the system (staff believes the answer is yes); does this also include children and youth who are currently in the system (staff is not clear on this and asked for clarification).

### Commissioner Questions/Comments

Commissioner Lee said it is his understanding that if the children and youth are in the system then they are already receiving some levels of service and this is why it does not include them.

Ms. Whitt said there are those who would take the position that there are sometimes youth who are currently involved in the system and have not yet been identified. Should those youth who are currently in the system but who have not been previously identified have access to the PEI funding.

Commissioner Poat said it was inferred that it would be the first contact but it was wrongly assumed that the need for services would not have necessarily been diagnosed on first contact.

He believes that the broader language is appropriate because we don't know which involvement of the system they will be diagnosed and perhaps lead to services that they need.

Commissioner Chesbro said the idea was that it was the first contact in which there was a possible diagnosis.

Vice Chair Gayle said a child could be in the system and not have displayed signs of behavioral and emotional problems until later, so that person who may have been currently in the system may not have had a break until later down the line and we do not want to exclude those people.

**MOTION:** Commissioner Kolender moved approval, seconded by Commissioner Poat to approve the more inclusive language by adding the words "who are currently in the system".

### **Commissioner Discussion**

Commissioner Dobson asked for an amendment of the motion to stipulate: "who are currently in the system at the first point of identification of signs of behavioral or emotional problems." Commissioner Kolender agreed to the friendly amendment.

Commission Poat explained that PEI funds are eligible funds to pay for services so long as it is at an early point of diagnosis as opposed to if a diagnosis occurs later.

Commission Lee asked that this item be carried over to tomorrow in order to have staff provide some language and/or models that the Commission can look at. Ms. Whitt said she will prepare some sample motions and present them to the Commission at tomorrow's meeting.

## **IX. State Administered PEI Prevention Projects Update**

Ms. Pat Ryan, Executive Director of the California Mental Health Directors Association presented draft principles that CMHDA has proposed to the government partners with regard to decision making on statewide projects:

- Two sections that CMHDA believes are relevant to this discussion are:
- Section 155897A: The Department of Mental Health shall implement the mental health services provided by parts 3, 3.6 and 4 of this Division through contracts with county mental health programs or counties acting jointly.
- Section 3E, which states that the general purpose and intent of the Act is to ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight.
- These sections should guide the discussion regarding statewide projects with the overarching goals of increasing cost effectiveness, facilitating the dissemination of best practices, and implementing them through joint county state collaboration.
  - Principles:
  - The proposals for statewide projects must be brought to government partners by one or more of the government partners for review and approval to ensure compliance with the MHSA and the agreed upon principles.
  - Statewide projects must contribute to the cost-effective implementation of the MHSA and to efficiency and service expansion to our communities.
  - Statewide projects must represent best practices and promote the efficient dissemination of these practices to participating counties.
  - Statewide projects must have performance and outcome criteria that are clearly specified and contribute to the goals of the MHSA.

- If the statewide project is implemented and is determined to be in-effective, a mechanism for timely termination by all parties must be specified.
- Proposals and agreements for multi-year statewide projects will be subject to the government partners' determination of available funding on annual basis.
- Statewide projects must meet the financial sustainability and leveraging criteria established for all MHSA projects when agreed to by the government partners.

As an explanation, government partners, is a group of four organizations that are specifically mentioned in the Act as having decision making responsibilities. They are the State Department of Mental Health, the Oversight and Accountability Commission, the California Mental Health Directors Association, and the California Mental Health Planning Council.

Commissioner Poat asked if there is any representation for family members and consumers in these government partners. Ms. Ryan said there is not. Vice Chair Gayle said this is alarming to him when the philosophy is "nothing about us without us". Papers are being presented to the Commission that have not received input from consumers or family members.

Ms. Whitt said the function of this group is one of coordination to make sure that everyone is communicating with everyone else, but it was very clearly stated that there is to be no decision making that happens at those meetings. Government Partners serves as a communication vehicle and protocol is that representatives bring all issues back to their appropriate entity. Vice Chair Gayle said this does not set well with him that something can be created without the input of consumers and family members. This information being presented may have items not included because there was not input from the consumers and family members.

Ms. Ryan said she is bringing CMHDA's proposed principles to OAC because they wanted to have a full discussion of the principles. Commissioner Chesbro said he attends the government partners meetings, but if there is someone else on the Commission that would be more representative of the consumer or family viewpoint perhaps Chair Steinberg can appoint someone else.

Commissioner Prettyman said there are instances where consumers and family members have different perspectives than the government partners group and it would be more encompassing to have consumers and family members.

Government Lee asked what the specific responsibilities of the government partners are within the Act. Commissioner Chesbro said he views the government partners are primarily preventative in that they report to one another what each is doing.

Commissioner Hayashi said if the mental health directors are one of the partners of the government partners and if they are reviewing and approving applications is this appropriate. Ms. Ryan said the principles she presented does not apply to reviewing grants. In creating a statewide program a decision has to be made if it is cost-effective and more leveraging is created: who makes that decision? What do counties do when some of the stakeholders decide that they are going to propose something that is not consistent with the Act.

Vice Chair Gayle said he would like to have this subject brought back for further discussion regarding the inclusiveness and transparency to develop these kinds of papers without input from consumers and family members from the conception to completion as far as the government agencies are concerned.

Commissioner Lee said the paper is well thought out and perhaps merit should be given to the other items that Ms. Ryan presented.

Ms. Emily Nahat, Chief of Prevention and Early Intervention for the California Department of Mental Health updated the Commission as follows:

- Several projects have been approved under PEI:
  1. Statewide Suicide Prevention with \$14 million annually for four years plus \$500,000 for two years for conducting the statewide suicide prevention strategic planning process. It was noted that \$4 million of these dollars has been directed to the Student Mental Health Initiative. The Advisory Committee is developing a statewide suicide prevention plan for California. A draft report will be produced and the stakeholder input process will be held on September 19 in San Diego and on September 21 in Emeryville. The draft will be presented to OAC at its September meeting. The revisions will be made from the input received and completed in November for presentation to the OAC at its January meeting. This plan is due to be delivered to the Governor by May 2008.
  2. Statewide Stigma and Discrimination Reduction project for a total of \$20 million annually for four years.
  3. Statewide Training Technical Assistance and Capacity Building for partners for a total of \$12 million annually for four years; from this fund \$6 million per year will go to the Student Mental Health Initiative. Once the PEI guidelines are finalized it will be known what they will work toward on training and technical assistance.
  4. There has been approval for spending 5-8 percent of the MHSA county level PEI fund for statewide evaluation. Any planned expenditures will be brought back to the OAC for the statewide projects.
  5. Up to 50 percent of the PEI services funds will be set aside for prudent reserve.
  6. There is \$15 million annually for four years authorized for ethnically and culturally specific programs and interventions.

Commissioner Lee asked what amount of the 51 percent will go to the ages of 0-25. Ms. Nahat said there is explicit direction on the county expenditures that 51 percent or more of the county expenditures should be for the age 0-25, but it has not been explicitly stated on the state administered projects.

Aaron Carruthers said he works for Chair Steinberg and is an employee of the California State Senate. Aaron provided the following update:

- In response to the Virginia Tech tragedy the Commission decided to have a proactive response and put together a package for funding a Student Mental Health Initiative, and at their June meeting, the Commission approved \$60 million dollars in funding for this initiative, but not the details of the funding.
- An advisory group of stakeholders was put together to provide the details. The stakeholders were divided into two groups; K-12 and the university system student mental health needs. He hopes to have a product to the Commission at the September meeting.

## **X. PEI Guidelines**

Ms. Emily Nahat presented the draft proposed PEI Guidelines as follows:

- DMH/OAC agreements on content and process

- User friendly, expedient, simple
  - Reflects the agreements of Government Partners document of January 26, 2007
- CMHDA Guidance
- Format/packaging
- Address specific issues, e.g., small counties
- PEI is the key to transformation with a help first approach rather than a fail first approach.
- The key community needs and PEI priority populations were reviewed. Reducing disparities and access to mental health services is a foundation of the MHSA and listing this as the first key community need and underserved cultural populations is a PEI priority population places an emphasis and overarching goal to reduce disparities through PEI services.
- The definition being proposed in the draft guidelines for prevention involves reducing risk factors or stressors, builds protective factors and skills, promotes positive cognitive, social and emotional development, and generally there are no time limits.
- The operational definition for early intervention is that it addresses a condition early in its manifestation; is of relatively low intensity; relatively short duration (less than one year); has a goal of supporting well being in major life domains and avoiding the need for more extensive mental health services; and may include individual voluntary screening for confirmation of potential mental health needs.
- An exception has been written to the PEI operational definition of low intensity and short duration in order that the types of transformation services can be implemented.
- Community Program Planning Process for PEI:
- DMH tentatively plans to release an information notice informing counties that they have planning funding available to them. It is hoped to release the funds in August, depending on the OAC's approval.
- So the community program funding will be out early with a very simple application process. Once the county goes through the process they will report in the program and expenditure plan for PEI that OAC will review.
- PEI Work plans: Work plan is one or more strategies for one or more PEI priority population to achieve desired PEI outcomes at the individual and family level, the program and system level, and if applicable, the community level.
- Counties will select strategies based on PEI Priority Populations and key community needs. They may select from the PEI resource materials, or alternative strategies with a rationale. Reducing disparities is an overarching goal and there is the requirement for priority age (51 percent of the county funds will go to children and youth 0-25; small counties are excluded from this requirement).
- Funding: DMH reiterates the non-supplant requirements from the Act. Some allowable expenditures would be those that meet the PEI operational definition and non-allowable expenditures might include areas such as filling gaps in extended treatment services, subsidizing academic degree programs, etc. Leveraging is a principle for all PEI investments.
- Accountability and Evaluation: some proposed evaluation questions for PEI are at the individual person and family level; did we improve mental health status; did we reduce risk for emotional and behavioral problems? At the system level, how was the PEI money spent? What strategies show promise or evidence of being effective especially with underserved populations? What impacts are there from PEI on the mental health system and other organizations, agencies and systems?
  - The Department will be looking at community level outcomes, which are the 7 aims in the Act to reduce the negative outcomes from untreated mental illness in regards to suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and removal of children from their homes. The Department will be working closely with OAC on this.

- Submission guidelines consists of a set of 7 forms, plus narrative attachments as needed for counties to submit their PEI program and expenditure plans.
- PEI Resource Materials is provided to assist county mental health directors and partners to identify practices that are evidenced base practices.
- Initial comments from the stakeholders on the draft of the guidelines are:
  - People want to be sure that the recent decisions of the OAC would be incorporated in the guidelines.
  - There were questions about county flexibility versus state direction. One question was around the age span requirement and another was on the emphasis on non traditional providers.
  - Comments regarding PEI funding:
    - Supplant
    - CSS versus PEI
    - Training
    - Access to State Administered Project funds
    - Screening

Comments regarding evaluation:

There was a concern that small counties might have limitations

People were concerned that outcomes were expected in 18 months

Level of rigor for local and state evaluation

Resource Materials

Might there be additional strategies

Are there an adequate number of school strategies

Next Steps: August 8 close of stakeholder comment period; August 10-31 DMH prepares revisions based on OAC and stakeholder comments. On August 31 it is hoped that the revision will be completed and provide an opportunity for OAC to take another look before final version which is hoped to be release in September.

### **Commissioner Questions/Comments**

Commissioner Chesbro noted that what the Commission had suggested in its January proposal regarding requiring local partnerships with non-traditional providers has not been incorporated in the way that OAC recommended. Ms. Nahat said this has been a topic of much discussion. Both are allied and it is an objective of PEI to work on non-traditional natural community settings. If counties choose to use traditional mental health provider partners, they must provide information about why they think that choice provides the best access.

Commissioner Lee asked who the stakeholders are in this process. Ms. Nahat said in April there were two stakeholder meetings with broad representation of consumer and family members as well as mental health providers. People were also represented from underserved communities, community clinics, social services, law enforcement and education.

Commissioner Poat asked if this is the principle time for comment. Ms. Whitt said OAC has two opportunities for comment. Today is the main opportunity and then there will be time for comment at the regulation process. Commissioner Poat asked Ms. Whitt if the Commissioners will receive staff review and recommendations. Ms. Whitt said another document could be prepared if that would be helpful, and Dr. Lee might be able to make comments at today's meeting as well.

### **XI. PEI Planning Estimates, PEI Community Program Planning**

Ms. Carol Hood with DMH presented the following information:

- Funding is one of the decision points for the Commission to approve the funding for PEI. The first step is for the Commission to advise what the total amount is that should be dedicated to local programs. The second step is the overall amount of investment to be put in the local process.
  - Recommending that \$25 million be dedicated to the process.
  - DMH needs to know what information OAC will need. Does OAC want more information at this point or would the brief one page application suffice. There will be time implications if strategies are changed to provide more information.

Commissioner Lee said he feels uncomfortable making decisions without having the documents in front of him to review. Commissioner Poat asked what the Commission's strategy is for the review of this document. Ms. Whitt said there are three items that need action: (1) \$25 million be used for Community Planning Process; (2) \$90 million and an additional \$192.6 million be used for local assistance in order that counties have the capacity to do a stakeholder process; (3) OAC's plan review process which Deborah Lee will present later.

Ms. Whitt told the Commissioners that she will make a copy of the document Dr. Lee is requesting and have it available tomorrow.

Commissioner Dobson asked when the OAC's initial input was made and in what form. Dr. Lee said when the first draft of the guidelines came out there was concern about the content, bulk, size, etc. Commissioners Feldman, Steinberg, Ms. Hood, Dr. Mayberg and Ms. Bush met to talk about the concerns. Then staff worked on implementing the concerns, i.e., make the guidelines more efficient, more user friendly, and consistent with the agreement that the Government Partners had ratified in January. She and Dr. Feldman provided his own personal input on the second draft. The latest draft does not reflect this second round of feedback from her and Dr. Feldman. OAC has not taken an official position on the guidelines except through the work of staff.

Even though the current draft that is posted does not reflect the latest comments, it does not mean that there is not a collaborative intent and it is not moving forward.

Ms. Hood said she is asking if OAC is on the same timeline and philosophy with DMH so that it can be finalized and money can get out to the counties. Dr. Lee said when the Commissioners see the form they will be able to say "is this sufficient or not" because it is not going to be complicated. Ms. Whitt will have all the necessary paperwork to the Commissioners tomorrow so they can better make a decision.

Ms. Hood continued her presentation as follows:

- The process for the global funding levels, which is the amount of investment statewide that will be put into the local level. From that there is a planning estimate for each of the counties that they can apply for, so for PEI funding the process that DMH believes is consistent with the Legislation is that the OAC and CMHDA meet consensus. CMHDA has approved what is being presented and then DMH needs to concur. And then after that DMH develops the county specific planning estimates with input from CMHDA regarding principals for distribution.
- Global planning amounts: Community Planning Process is \$25 million; PEI local assistance is \$90 million and for 08-09 \$192.6 million.
- The Department is trying to get a full year's cash in advance because this is such a volatile funding source. The Department would like to begin paying counties 75% at the beginning of the year and then 25% mid-year when they have submitted required fiscal and program reports. She will look into a better way to track this so that the Commission

can actually see what is happening with all the money because the current format does not do this.

## **XII. PEI Evaluation and Accountability**

Ms. Carol Hood with DMH presented the following information:

- Where are we going with accountability and evaluation?
- The Department has tried to create an overall vision as to where it is we are going.
- The Department would like to proceed with the PEI evaluation with the understanding that it will become a part of a larger MHSA evaluation.
- The principles that are being worked on are: (1) demonstrate accountability to the public; (2) document progress to meeting the aims; (3) advance the state of art; (4) be objective; (5) be timely; (6) be feasible; and (7) be sustainable.
- We want to be able to tell a convincing story.
- The Department's role needs to be to look at what is going on and how can it make things better
- There should be a rigorous independent assessment of effectiveness of PEI; one to supplement and look at specific issues.
- The Department believes there needs to be a mix of internal and external evaluation and have established criteria for when this should be used.
- The Department believes the primary things it should look at are:
- The guidelines will flow into the accountability system by having the county provide the workplans, the Department approves them, and then at the end they provide a narrative of what happened in those services, as well as the expenses.
- The Department wants broad based teams to provide the on-site program reviews
- Status of community partnerships is a critical component of prevention and early intervention, to leverage and expand who its partners are.
- Local evaluation of specific county based strategies – counties are required one local evaluation and they would describe this in their workplan.
- The state administered projects will also be evaluated.
- The proposed next steps are to obtain Commission direction on the decision of the inclusion of state evaluation of several county based strategies and then obtain input on the later decisions in this document.
- There is a proposal between the different Government Partners to establish an Evaluation Coordination Committee consisting of the OAC, DMH, the Planning Council, and CMHDA have a committee that also includes client and family members, as well as providers to specifically look at coordinating evaluation activities on the MHSA. This is actively happening.

### **Public Comment**

**Mary Rainwater**, Project Director for the Integrated Behavior Health Project, which is a four year initiative funded by the California Endowment with the purpose of looking at integrated behavior health as a tool for reducing stigma and increasing access to mental health services for underserved populations, particularly, in primary care clinics. She is supportive of the community clinics and other non-traditional mental health providers being part of PEI. She has learned two things about integration: (1) it is not an easy thing to do or it would have already been done; (2) language is extremely important.

In a situation where those relationships are not already there necessarily, the language becomes very important and she encouraged the Commission to make sure that the guidelines include the specific and direct language that it feels protects the process of integration and transformation.

**Lucrecia Campos-Juarez**, Director of Mental Health Services for Teen ? in Ventura County, said she has 9 community clinics throughout the county providing mental health services at each health center. She has concerned that unless language is used that would require counties to include community health care clinics as one of their partners, it will be business as usual. She wants to be at the table and partner with the county departments to ensure that this is implemented the right way. In addition, she would like to see specific questions in the evaluation process to make sure counties are addressing how they are outreaching and including the non traditional partners.

**Nora O'Brien**, Senior Program Analyst from the California Primary Care Association, said the Association serves 3.6 million patients and of those 52 percent are Latino, 8.6 percent are African American, 10.6 percent are Asian, and 1.6 percent are Native American. The Association has a long history of serving underserved populations and everything it does is about cultural and linguistic competence. To have a better understanding of community clinics and health centers, 200 percent of poverty is about 82 percent of their patients and 48 percent of their patients are limited English proficient. Without the prescriptive language that was adopted by this Commission in January that spoke to the issues of non-traditional mental health, community health care clinics will not be able to create a seamless mental health system. She wants the PEI final guidelines reflect the language adopted in January. It is also important to evaluate counties by its partnerships with community based organizations.

Commissioner Chesbro asked if by using more prescriptive language in the guidelines would exclude more traditional providers. Ms. O'Brien said not at all because by saying to include additional providers in the provider network is not excluding existing providers.

Commissioner Chesbro said he would like to again see the Commission communicate to the Department what was communicated in January, which is that those community based providers, such as community clinics are included.

**Rusty Selix**, Executive Director of the California Council Community Mental Health Agencies (CCCMHA), said he sees two problems. The first is, the planning process for the counties to use has never been discussed. We cannot let the planning process for PEI be like it was for Community Services and Supports because it was a disaster. The process needs to be strategic and focused and he said he can provide his written recommendations. His message to the Commission is before it approves any county plans there needs to be some discussion on what the planning process should look like.

Secondly, the guidelines speak to require participants at the local level. None of those groups, other than the primary care plan, are here today. The August 9 comment deadline will not be met by the education groups, law enforcement, and all other groups who should be commenting on these guidelines. The state has made no effort to reach out to them as the state is directing the counties to reach out to in developing these guidelines. He does not believe that we can go forward until both of these issues have been addressed.

**Dr. Frank Andrews** said he is a former mental health director of a primary health care clinic in San Bernardino, who he is representing today. This clinic serves underserved populations and has done so for the past 20 years. It serves a broad spectrum, seeing 400 patients a day. The original language in the guidelines said that the county will seek out, identify, and form partnerships with organizations such as his and he was heartened by this. However, in the new language this is not there. If the original language is not in the guidelines directing that this be done, it will not happen.

**Carmen Diaz** asked what will prevent the Exception to the Rule in the PEI guidelines from turning into long term for everyone. She asked if there is a safeguard in this exception which will keep it from going into long term treatment. PEI is time limited and she asked how children will be served in the juvenile justice system if they can only be served for 6 months to 1 year. She hopes that when the evaluations are done that someone goes out and has the people that are receiving the services evaluate their service.

**Nahla Kayal** said she is the founder and executive director of Access California Services, which is a family resource center established in Orange County in 1998 to serve the economically disadvantaged and culturally isolated Muslim and Middle Eastern community. To date, Access is the only service provider in California to this community. In 2006-2007 Access served more than 2,600 clients, serving clients in more than 8 languages. She urged the Commission and the counties to help with funding for her community.

**Brian Lee**, First 5 Invest in Kids, said he will be addressing the priority population juvenile justice issue. As the Commission works on language, he asked them to use the title of “At Risk of or Experience in Juvenile Justice Involvement”. As the “first diagnosis” issue is looked at he has a few concerns. We do not want to leave out any PEI services; pre-diagnosis, mis-diagnosis; post-diagnosis. It has been suggested that CSS dollars could be used for post-diagnosis, but this would be for seriously emotionally disturbed kids only. There are a huge number of kids who are in the JJ systems, have a mental disorder, but are not seriously emotionally disturbed and PEI is what fits for them.

Providing services early in the diagnosis is something that is the basic principle of PEI that applies across all six priority populations. There is no reason we should specify this just within the juvenile justice. He suggested that if we have something on first diagnosis it would be an alternative, not a substitute, for some of the existing language. Secondly, first diagnosis is something that applies across all the populations and should not be singled out in the JJ system.

**Renee Compton** said she is speaking for the children. She was involved with the system and could have been taken away from her mother but instead sent her back to her mother where she spent another 15 years being abused. When a child gets involved with the system they have a problem and there needs to be a way to help them and not just send them back home. Upon first contact the child should be assessed. She is a peer support specialist and did not understand what was being talked about today. She asked that “people English” be used so consumers can understand what is being discussed.

**David Quackenbush**, from the Central Valley Health Network, said the Network is a consortium of federally qualified health centers with 116 sites in 20 counties. The guideline language should ensure that health centers be included as the non-traditional provider. He encouraged the Commission to look at CPCA’s letter and adopt the recommendations they have regarding language. Federally, qualified health centers are required to have a consumer board, which means when a federally qualified health center decides to start a mental health service, it is approved at the Board level in which there are consumer and patients of the health center making part of the decision.

There was a clear discomfort by several Commissioners today of the transparency and lack of information that they are receiving. He encouraged the Commission to take the time they need to make the decision regarding these guidelines because it is his belief that the provider community would understand and would end up with a better product.

**Judy Ann Adams** said the issue that concerns her is consumers being left out of the Government Partners meetings. She does not appreciate being left out. There were decisions made that are

being proposed by this group of partners and there are two issues on the agenda that she is very strong about. One is cultural competency and the other is suicide prevention. She is a survivor of suicide. She would wake up each morning having the biggest battles of her life with her head telling her to die and her heart telling her she don't dare. She refused to talk to anyone about it because they would lock her up for five years. She hopes the Commission will take this into consideration when suicide prevention is being discussed.

**Michael Smith**, from the California School Health Centers Association, said he will be submitting written comments on both the PEI guidelines, as well as the Student Mental Health Initiative. The first point he made was that the Association was encouraged to see school health centers mentioned in sections of the PEI draft guidelines. The Association would also like to advocate for the inclusion of schools and school health centers throughout the documents, both in the PEI and the resource material, to ensure that the services meet youth 25 and under, as well as several priority populations. Secondly, the development of Student Mental Health Initiative is a unique opportunity to demonstrate the effectiveness of a comprehensive school mental health program. However, the Association does believe in order for a program to be comprehensive it must include a continuum of care with PEI and treatment services.

**Jim Rothblatt**, a licensed therapist in California and a consultant in prevention education, said he would like to recommend and encourage making a greater effort to let people in the schools know that early intervention is available. He said that elementary teachers probably do not know that this is even a possibility. Educators are too few people being asked to do too much and if this Commission can somehow bring mental health into schools it would be appreciated.

**Delphine Brody** said she would like to echo Commissioner Gayle's sentiments that clients and family members should have formal and equal standing with government partners in every stage of the planning, review, and approval process. She proposed a modification to the first recommended suggestion that proposals for statewide projects must be brought to government partners, clients, and family members. The same would be true for No. 7, statewide projects must meet the financial sustainability and leveraging criteria established for all MHSA projects when agreed to by government partners, clients, and family members.

Regarding suicide prevention and stigma and discrimination reduction statewide projects she has a number of comments. Older adults need to be included much more in suicide prevention. Youth should be represented throughout the PEI process. The best responses to discrimination and stigma are client driven and civil rights should be included and not buried underneath other priorities. Rather than focusing on screening, she supports people having universal access to services and assessments based on client choice, including self assessment of their needs.

**Erika Hainley**, Manager of Social Services at the Children's Clinic which is a community clinic in Long Beach, said the Clinic has 6 sites in Long Beach serving 17,000 patients being served by a diverse and multi-lingual staff. The Clinic supports California Primary Care Association's letter with their points on language. The reason that community clinics and other community based organizations need to be involved are because they are already seeing these individuals and they are a population they have been working with. They have the capacity and diverse workforce to serve this population. There are other places, such as domestic violence shelters and schools where having counseling on-site would make a big difference. Clinics need to be embraced as part of the mental health system to be brought in as providers since they are delivering these services in large numbers now.

**Alaina Dall**, Director of Policy and Community Health with the Council of Community Clinics based in San Diego, said the Council supports 17 clinic corporations providing services at 80 locations in San Diego. Twenty of the locations provide mental health services on site. The Council was one of only two clinic associations to receive funding on behalf of its member clinics

from MHSA Community Supports and Services. To date, clinics have served over 250 clients with this funding. The Council would like to assure that clinics statewide have the opportunity to participate in the PEI planning process and receive funding to provide services in the clinic setting. The Council would like to see the language strengthened in the guidance that support services in non traditional mental health settings, including community clinics. It would prefer to see the language preserved from the January 17 PEI plan requirements that county and state PEI program design builds integrated and coordinated systems, including linkages with systems not traditionally defined as mental health.

**Dr. James DeCarli**, with the Los Angeles County Department of Public Health Injury and Violence Prevention Program, suggested considering integrating public health department's role in addressing intimate partner violence, and suicide among the proposed prevention and early intervention and in the co-occurring disorders, as well as in government partners (speaker goes out on recording and I cannot hear what is being said from this point forward).

Rocco Cheng, Ph.D., from Pacific Clinics, said they have one of the most successful parenting programs in the nation. The non-traditional approach can engage people and then provide PEI services. He urged the Commission to consider inclusion of immigrants in the language of underserved cultural population. The needs of immigrants are different; their life experience is different; and the barriers for them to come to the mental health service are also different.

Many programs are not validated in diverse cultural communities which are in direct conflict of providing culturally competent and appropriate strategies to the community. Some of the evidence based programs border between treatment and prevention or early intervention. This is a major concern because you are trying to engage in non traditional agencies; however therapies or treatment are being provided to the high risk family target population.

He is not clear what the term "low intensity" means. His programs is very untraditional with many prevention programs and he hopes that traditional agencies will not be included in the PEI initiative.

**Zula Reeves**, said prevention can start at any age. She understands it is important to help the children, but we need to remember middle age and older who will be needed help as well. Prevention should include these people. Measurable outcomes are needed in the areas of school failure, homelessness, and law enforcement. She is tired of hearing the word "system". What system are we talking about; which political system are we talking about? We need to help people get better.

**Andrea Gordon**, Director of Mental Health Programs for the L.A. County Probation Department serving both adults and juveniles, said she noticed that in the planning guidelines there is no distinction made for adults being served by the criminal justice system who may be in need of prevention and early intervention. In regards to the youth, the issue of contact with the justice system is not made clear. First contact could be from the arrest by a police officer, and it is not a police officer's job, nor are they sufficiently competent to make assessments about health issues for any child or youth. There is no greater fear for parents or families, than to see their children or youth spiraling out of control, heading down a path of career criminals when there has been no opportunity for diagnosis. The MHSA was not passed by the voters of California to prevent or provide early intervention for delinquency or crime. It has to do with mental health issues. She asked the Commission to keep in mind the development of language that will effectively include all youth who need mental health.

**Chris Reilly**, Behavioral Health Director for Clinic of Sierra Vista, and a QAC in the central valley and a contract provider for the local mental health system of care, said he has had a chance to see a variety of mental health and behavioral health services from two perspectives and two

systems. He emphasized that any effective preventive and early intervention effort to discover and reach underserved people and overcome the culturally based and other stigmas and barriers to access care must include a substantial for community health care centers. He respectfully asked that the guideline language be strengthened to make clear that one of the goals is the full inclusion of CHCs and non-traditional sites for service delivery, as well as participants in new program development. He endorses the CPCA written comments that was submitted to the Commission on July 23, 2007.

Vice Chair Gayle said all voting will be deferred until tomorrow's meeting. Material will be delivered to the Commission's rooms this evening, as well as the one page form for the Community Planning Process in order that members have the opportunity to review the information before the vote.

Meeting recesses at 5:30 p.m.