Mental Health Services Oversight and Accountability Commission
MHSOAC
Meeting Minutes
March 24, 2011

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

1. Call to Order

Chair Poaster called the meeting to order at 9:10 a.m.

2. Roll Call

Commissioners in attendance: Larry Poaster, Chair; Richard Van Horn, Vice-chair; Richard Bray, Bill Brown, Patrick Henning, Howard Kahn, Ralph Nelson, Jr., Andrew Poat, and Eduardo Vega.

Not in attendance: Senator Lou Correa, Assembly Member Mary Hayashi, David Pating, and Tina Wooton.

Eight members were present and a quorum was established.

3. Adoption of January 27, 2011 Mental Health Services Oversight and Accountability Commission (MHSOAC) Meeting Minutes and February 24, 2011 MHSOAC Teleconference Call Minutes

Commissioner Poat had a slight rewording to the January 27, 2011 Meeting Minutes and would explain to staff after the meeting.

Commissioner Brown had a slight correction to the February 24, 2011 Meeting Minutes. On page 3 he would like to delete the word, “physical” and replace it with the word, “recreational”.

Public Comment: No public comment.

Motion: *Upon motion by Commissioner Henning, seconded by Vice-chair Van Horn, the Commission voted unanimously to adopt the amended January 27, 2011 and February 24, 2011 Minutes.*

4. Evaluation Committee

Ms. Carol Hood, MHSOAC Staff, gave a briefing on the status of the MHSOAC statewide evaluation effort for Phases 2 and 3, summarized below.

- As a result of a competitive bidding process the University of California, Los Angeles (UCLA) was awarded the contracts for Phase 2 and Phase 3.

- For Phase 2, funding is $500K per year for Fiscal Year (FY) 2010/11 and FY 2011/12. UCLA's first deliverable is due on May 1, 2011.

- For Phase 3, funding is $1M for FY 2010/11. UCLA's first deliverables are due on September 30, 2011.

- Approximately $35K has been identified in MHSOAC unexpended funds and will be used to fund an interagency agreement with UCLA to develop a summary and synthesis of Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) evaluation efforts. The deliverable due date is August 31, 2011.

- MHSOAC also has a contract with University of California, Davis (UCD) to provide an analysis focused on disparities in mental health care, and an analysis of the mental health part of the California Health Information Survey (CHIS).

Ms. Hood invited Dr. Franke, Associate Professor of Social Welfare, UCLA School of Public Affairs, and Dr. Estella Geraghty, Assistant Professor of General Medicine, UCD School of Medicine, to talk about their approaches to the evaluations.

University of California, Los Angeles Presentation on Evaluation Activities

Dr. Franke gave a presentation on the effort at UCLA. Highlights are below.

- The overarching evaluation framework is based upon the idea that evaluation should be participatory and it should be utilized. The UCLA team will:

    - Meet with a variety of stakeholder groups.
    - Map information needs in complex service systems providing continuous services.
    - Work with integrated data collection systems and conduct analysis that supports continuous quality improvement.
    - Partner with key stakeholders to develop recommendations for a performance monitoring system.

- Deliverables for Phases 2 and 3 are various reports, summaries, and recommendations.

- UCLA brings a multidisciplinary research, policy, and training approach to its work which is beneficial to all projects.

- Dr. Franke read the mission of UCLA Center for Healthier Children, Families and Communities.

- UCLA is partnering with Evaluation, Management, and Training Associates. Dr. Franke read their mission statement.

- The Phase 2 contract has been executed and the kickoff meeting was held on January 27, 2011. The kickoff meeting for the Phase 3 contract is scheduled for March 30, 2011.

- UCLA's orientation to evaluation is utilization-focused. UCLA will focus on producing information which is useful for decision makers and other key stakeholders. End-users of evaluation data will be integrally involved in development and implementation of the evaluation. Data collected and feedback delivered must be meaningful, useful, and timely.

- UCLA uses the evaluation framework that the Center for Disease Control and Prevention has been using.

- The Phase 2 and Phase 3 evaluations entail a logical sequence of activities, beginning with engagement of stakeholders.

- The process should be participatory, and to that extent, there are principles for engaging stakeholders. It's very important to hear from everyone and to understand alternative points of view. The goal is to build collaboration by identifying and engaging key stakeholder groups.

- Dr. Franke listed bullet points on what the MHSOAC can expect.

    - Existing data will be used whenever possible.
    - When new measures are created it will be done so out of existing data whenever and wherever possible.
    - Cross-site reports linked to client impact may not reflect unique features and characteristics of each county. Additional system-level data may need to be gathered.
    - At least 30 days notice will be provided before launching a web or telephone survey so that stakeholders have adequate time to reply.

University of California , Davis Presentation on Preliminary Findings from Mental Health Tracking

Dr. Geraghty gave a presentation on the mapping of access and utilization of mental health services in California. It included technical components of cartography and spatial statistics. Highlights are below.

- The UCD team used the Medi-Cal billing database to analyze and map disparities in service access and delivery at the local level. Subgroups of age, gender, and race/ethnicity were reviewed. Race and ethnicity are combined in the Medi-Cal billing database.

- The team focused its efforts on adults between the ages of 18 – 64 with a serious mental illness (SMI) and children between the ages of 12 - 17 with a serious emotional disability (SED).

- *Access to Care* can be defined by *penetration rate*: a common measure reflecting the proportion of individuals in a given population that use specialty mental health services in a year.

- *Service delivery* is characterized via the *utilization rate*: the total number of mental visits per mental health Medi-Cal beneficiary. The team used outpatient visits only.

- *The following types of maps were not used by UCD due to their limitations:*

    - A choropleth map – This type of map represents the penetration rate for a particular age group with darker colors indicating a higher penetration rate. This map contains a lot of census tracks and makes it difficult to draw inferences.

    - A map showing classification by quantiles - This type of map has even color distribution; however, ranges vary widely on the map, it can be misleading, maps are not comparable, and patterns are not easily seen in the data.

    - A map showing equal intervals - Issues with this type of map are the human eye is drawn to the bigger- and darker-colored census tracks, leading to bias, most census tracks are too small to see clearly, and the eye has difficulty discerning multiple colors.

- The data display method the team decided to utilize was *Hot Spot Analysis*. It allows for testing of the statistically significant clusters of a variable (such as the penetration rate). Hot Spot Analysis shows penetration rates that are

significantly higher or lower than the state mean. High values are *hot spots* (shown in red); low values are *cold spots* (shown in blue).

- For groups of interest (SMI and SED), Dr. Geraghty created charts showing utilization and access by county. She assigned colors to show rates.

- Next Steps:

    - Understanding service access without understanding mental health need only tells a part of the story.

    - Need can be determined in California using data from the CHIS.

- In summary, hot spot analysis provides an opportunity to see statistically significant patterns in large datasets which may help guide resource allocation and track change over time.

- Access to care and utilization could be refined to show how the population receiving services compares to the population in need.

Dr. Geraghty answered questions from the Commissioners. Commissioner Kahn asked about the impact of undocumented workers using emergency Medi-Cal, on the need and utilization numbers. Commissioner Henning asked a similar question about the prison population, which does not receive Medi-Cal. Dr. Geraghty responded that their analysis is limited by the data that is available; the data in the Medi-Cal billing database was used and the results should be interpreted with caution. Dr. Geraghty also indicated that there are some statewide efforts to merge the county Client and Services Information System data with the Medi-Cal data which would provide some data on prison populations.

Commissioner Kahn questioned how access was defined. Dr. Geraghty responded that every patient in the Medi-Cal database was defined by their International Statistical Classification of Diseases and Related Health Problems (ICD) – 9 codes. Commissioner Kahn and Dr. Geraghty both indicated that there is a need to measure provider presence.

Vice-chair Van Horn pointed out that the data does not capture Medi-Cal eligible individuals who are in need of treatment that do not access services.

Commissioner Poat asked how to gauge the appropriateness of the service rendered to the need of the client. Dr. Geraghty replied that using billing data makes gauging the appropriateness difficult. The database indicates the type of visit, such as group visits, case management visits, and pharmacy visits. If one had a way of determining thresholds of what would be considered appropriate

treatment for different diagnoses, one could examine appropriateness of treatment within the Medi-Cal billing data. Another data source or clinical trials would be needed in order to look at how services are being delivered. Commissioner Poat, to clarify, stated that what this data shows is that a service was rendered but does not show whether or not this service is what the mental health clients thinks they needed.

Commissioner Nelson inquired about people being seen as outpatients who ended up being hospitalized. Dr. Geraghty responded that this data could be obtained because *Dates of Service* were available; however, they were not specifically analyzed in this study.

Commissioner Poat appreciated the presentation and would like more mini-reports like this during the study. It is important to know how information impacts policy makers and what data the MHSOAC needs to request.

Commissioner Kahn would like to see some data on dates of service relative to when the Act was implemented (2007 – 2009). Data is needed from before the Act to set a baseline.

Commissioner Poat appreciated that the limitations with the data from the Medi-Cal billing database were addressed and indicated that the Commission can advocate for future data collections.

Chair Poaster and Vice-chair Van Horn emphasized that the Commission should know what data is not included that is nevertheless needed and what data is included that is not needed.

Vice-chair Van Horn asked about the level of collaboration between UCD and UCLA – since much of what UCLA will do is going to respond to information from UCD. Dr. Geraghty responded that Dr. Sergio Aguilar Gaxiola is leading the UCD component, and has had active collaboration with UCLA. Dr. Franke stated that action is underway for UCD to supply data to UCLA. UCLA will build on what UCD has found and not redo it.

Commissioner Poat wants the Commission to track policy issues and identify where the Commission wants to insert itself in the data collection design. Data collection is expensive.

5. <u>Public Comment (Please note that public comment was allowed on this item because the meeting was ahead of schedule.)</u>

- Ms. Kathleen Derby, MHSA Policy Coordinator for National Alliance on Mental Illness (NAMI) California, commented that NAMI California was very excited to see this evaluation getting off the ground, and was hopeful for a good outcome. She was pleased with UCLA's commitment to making

information available to multiple stakeholders and the general public. NAMI members have always expressed concerns about this. Clients and family members across California would be interested in becoming involved in the participatory research, design, and implementation of a study.

- Ms. Harriet Markell, Associate Director at California Council of Community Mental Health Agencies, was delighted with the work going on. She remarked that the Hot spot/Cold spot paradigm was being talked about more and more in mental health research. It was going to be important to include both research/clinical people and consumers/family members in interpreting the data. Also important in the development of a comprehensive state mental health system, is to find a way to combine datasets – i.e., MHSA and Medicaid. The appropriateness of care must also be looked at. Ms. Markell encouraged UCLA to include the 501(c)(3) organizations as they conduct their participatory research.

- Ms. Lin Benjamin, California Department of Aging, commented that the Department is looking forward to providing stakeholder input related to participatory research. The Department of Aging will be concerned that the analysis of access utilization excludes persons over the age of 65. Some seniors have dual coverage and seniors need to be analyzed too.

- Mr. George Fry, Vietnam era veteran, appreciated both presentations. He commented that he hoped to see a focus on Post-traumatic stress disorder, and he also hoped, along with Ms. Benjamin, to see senior citizens included in the evaluation.

Commissioner Kahn stated that he would like to find the balance between having sufficient input from all stakeholders, and at the same time insulating the researchers' conclusions from political and popular agendas.

Commissioner Poat indicated that when the report is done, it will be handed back to the Commission, who will need someone to lead in the effort to implement and sustain all these programs. The Commissioners had spoken for some time about the need for a practice leader of evaluation in the Commission process; plan review is not what the Commission will be doing in the future, and it needs to accommodate that change. Equally important, the Commission needs to move toward having someone who will take the handoff and start to operationalize it.

Chair Poaster agreed, stating that the Commission will be attempting to rethink how it looks at oversight related to outcomes.

Executive Director Gauger commented that staff is in the process of reclassifying vacant positions to support Research Program Specialist positions.

6. State Budget Update and Discussion

Administration Proposal and Conference Committee Action

Chair Poaster welcomed Mr. Cliff Allenby, Acting Director, Department of Mental Health (DMH).

Mr. Allenby mentioned that the first time he spoke to the Commission, he talked about the anticipated move from inputs to outcomes. Today, Governor Brown will be signing legislation that implements all of these changes. There will be changes to the structure, but like all new things, it will evolve with time. From having counties prepare plans, present them to the State, and have them approved, the MHSOAC will now be charged with establishing appropriate outcomes. The DMH will be different; Medi-Cal provisions will probably be at Healthcare Services; Proposition 63 will be dramatically changed from having counties come to the State to ask for the dollars – another system will be developed to allocate the dollars.

Mr. Allenby emphasized that no major bill has ever passed without undergoing significant changes in future years.

Interest groups will now be finding their ear at the county level. There will be significant changes in how the programs emerge.

The move from inputs to outcomes – a major move – should have been done long ago; but inputs are easier than outcomes. It is critical for the MHSOAC to facilitate the counties' movement toward examining what they can do to generate good outcomes.

The DMH, along with interest groups, will initially be looking at cleanup legislation.

At the request of Commissioner Kahn, Mr. Allenby described his vision of the MHSOAC's job going forward. It will be a struggle to determine appropriate outcomes and to listen to the community. Counties will no longer have to submit a three year plan for approval, so a structure will have to be determined over time to allocate the dollars. The bill envisioned that the dollars automatically go to the counties, based on the flow of income. What is not clear now, is who gets how much.

A limited number of programs will still be with DMH. DMH itself will be significantly different tomorrow than it is today. There may not even be a DMH that deals with the generic mental health areas. It is possible that another State agency or department will assume that role. For example, Medi-Cal changes in particular may be done by the Department of Healthcare Services.

The determination of the allocation of dollars is not going to be easy. Growth is going to be another issue. Now it is all based on inputs and plans, and works its way out. Reversion may work differently.

Chair Poaster made the closing comment that it is important to note what the trailer bill language did not affect in terms of the MHSOAC: the Commission will continue to oversee systems of care; Commission structure and operations remain the same in its oversight and evaluation capacity; and its structure and operations are still separate from DMH in terms of the five components of the Act. The bill did state the Legislature's intent was to ensure continued State oversight and accountability, and that in eliminating plan review and approval it intended that DMH in consultation with the MHSOAC will establish a more effective means of ensuring that county performance complies with the Act.

Commissioner Poat indicated that the Commission needs to be a practice leader and needs to think years in advance.

Vice-chair Van Horn thinks that the Commission should not be punitive, but should help the counties to achieve continuous quality improvement. Peer pressure and competition between counties would be positive because no county wants to be in last place.

California Mental Health Directors Association (CMHDA) Presentation on Impact of the $861 Million Redirection

Chair Poaster noted that in this presentation, the Commission was looking for real-life impact on the counties. Ms. Patricia Ryan, California Mental Health Directors Association (CMHDA) Executive Director, began by stating that CMHDA is still in the process of digesting the changes about to be implemented in the trailer bill and the budget, as well as digesting what the proposed realignment means to the counties.

Highlights of the presentation are as follows.

- The budget bill and trailer bill were going to be signed this afternoon. The Constitutional Amendment for realignment and the rest of the package have not been signed. On June 7, 2011 would be a special election where the voters would vote on a tax extension that would pay for realignment, and a Constitutional Amendment would go along with it.

- Over $6 billion in Health and Human Services Spending Cuts have been approved by the Legislature and are awaiting the Governor's signature.

- Individuals and families living with mental health challenges will be deeply impacted. Budget reductions will affect Supplemental Security Income/State Supplementary Income, California Work Opportunity and Responsibility to Kids, Adult Day Health Care, etc.

- CMHDA is looking hard at what happens if Realignment doesn't pass; another $6 billion in additional reductions must occur to balance the State budget. Much will come from K-12 Education, but further Health and Human Services reductions are likely. The MHSA diversion in the trailer bill will occur whether or not the Realignment passes.

- CMHDA's MHSA Redirection Proposal advocates for a "least harm" approach. It formed sequential steps for taking funds from the MHSA Fund and distributing to counties; a move to monthly deposit transfers to counties for MHSA funding; and flexibility on prudent reserve policies.

- Legislative Action in Senate Bill 76/Assembly Bill (AB) 100 clarifies in statute that the $861 million is a one-time diversion.

- The Legislature took CMHDA's advice for steps that should be followed in order to affect the MHSA available funds with the least harm.

- CMHDA is in the process of developing workgroups to look at the principles for fund distribution of Early and Periodic Screening, Diagnosis, and Treatment, Medi-Cal and AB 3632 for FY 2011-12.

- CMHDA is also seeking administrative efficiencies and flexibility on prudent reserve policies.

- This is not just a budget shift, but a major policy shift. CMHDA fundamentally supports the new Administration's policy shift to local governance with focused state oversight.

- Assembly Bill (AB) 100 also includes a reduction to the five percent cap on state administration dollars to three point five percent.

- CMHDA feels that cash flow to counties is simplified under AB 100. The language builds upon existing systems for fiscal accountability.

- Regulatory processes for counties are not necessarily streamlined.

- Unresolved issues are as follows.

  - Removal of plan approval authority at the state level does not reduce administrative burdens for counties and contractors.

  - Current reporting requirements are not resulting in timely performance outcome data and streamlined program compliance monitoring.

- There is a long list of programs included in the Governor's realignment proposal; they are not just mental health programs.

- In the Governor's proposed ballot language for the constitutional amendment, there are no provisions to require separate funding subaccounts or firewalls among each realigned program (at either the state or the local level).

- CMHDA's next steps are as follows.

  - Educate counties regarding the impact of changes.

  - Explore how to address unresolved issues from Senate Bill 76/AB 100.

  - Continue to advocate for firewalls or other protections to ensure adequate funds for 2011 realigned mental health services.

  - Identify recommendations on the realignment implementation statute; identify state laws and regulations that should be changed or eliminated.

  - In general, support the shift to local governance with focused state oversight.

Ms. Kristy Kelly, Lake County Mental Health Director and President, CMHDA, spoke on implications at the local level.

- The county mental health directors are change managers now. The changes are difficult and they are exciting.

- There are 38 small counties in California. When money stops flowing from Sacramento, they feel it first. The small counties are diverse with individual needs.

- Lake County has re-oriented all services around Full-Service Partnerships (FSPs), and bringing clients home from placements and back to the community as quickly as possible.

- There is learning that is happening through MHSA that's having profound impacts on local counties, and is helping to make a more responsive system.

Flexibility, taking resources and using them in ways that serve the clients and counties, is key.

- In the context of healthcare reform, the concept of integrated healthcare, physical healthcare and mental healthcare is tremendously exciting.

Commissioner Bray remarked that budget reductions will be especially devastating to the smaller school districts of California. Superintendents up and down the state are feeling like changes are being foisted upon them without a lot of dialogue.

Ms. Kelly responded that Mental Health Directors have felt a burden from Assembly Bill (AB) 3632 for many years. They want to ensure that children are not harmed as changes are effected. Most children in Lake County have access to Medi-Cal, and no matter how this issue ultimately sorts out, those children have access to federal entitlements.

Public Comment

- Mr. Fry suggested that the Commission hold a meeting in Calaveras County, so they could get a feel for what the small, rural counties are like. In rural counties there tends to be a "good old boy" system affecting allocation of money. Also, cuts are affecting veterans and Veterans Services Officers are being done away with. In addition, as an elected School Board Trustee, Mr. Fry has seen the devastating impact of AB 3632.

- Ms. Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition, commented that big changes are happening quickly. As an advocate, she stated that several wonderful, knowledgeable people are at risk of losing their jobs although they have made a great effort in pushing the system. These include Ms. Lin Benjamin, Ms. Betsy Sheldon, and Ms. Monica Nepomuceno. They help at both the State level and the local level. She was grateful that Reducing Disparities was spared. Ms. Hiramoto was concerned that the switch to local control might be difficult because advocates may not be able to speak freely due to fear of retribution.

- Ms. Eva Nunez, a mental health client since 1972, read a statement in honor of the California Network about empowerment.

- Mr. Jonathan Vickrey, a student at University of California, Merced and President of the campus chapter of the NAMI, pointed out that he felt that this group was being a bit delusional about taking away consumers' ability to advocate for themselves, and giving it to county representatives. From 2004, it took some counties three years to implement the first phase of the MHSA. Now, we are changing a process with no direction. He felt that the correctional system is a drain on statewide dollars. What we can do is take

the 207,000 juvenile detentions, at a cost of $215,000 per detention, that suffer from mental illness and treat them, thereby saving $29.4 billion per year.

- Ms. Caroline Caton, California Department of Social Services (DSS), was encouraged by the conversation of today's meeting. In her position administering wraparound services, she works with numerous mental health groups to spend funds in a different way. She encouraged MHSOAC to look not only to DSS, but to other state organizations working with MHSA. There may be existing expertise and existing efforts in place to take advantage of as MHSOAC looks at measuring outcomes.

  She also reminded everyone to keep the big picture in mind. It is important to keep the dollars flowing, but not to lose sight of a transformed system and still listen to the voice of families and consumers.

- Mr. Steve Leoni, consumer and advocate, commented on MHSOAC's set of principles regarding the Governor's fiscal proposal, including MHSA funds being used for voluntary participation. Also, MHSOAC may have a principle regarding training and leadership in a position with a statewide component that cannot be realigned to counties.

- Ms. Derby stated that NAMI California has already begun to advocate for the upcoming ballot measure – if it does not pass, we will be in serious trouble. She feared that client/family members will not have the protection of separate authority from their local level to which they can advocate. There is still a need for state leadership.

- Ms. Delphine Brody, MHSA and Public Policy Director at the California Network of Mental Health Clients (CNMHC), echoed the concerns of many other speakers for client/family members and unserved communities. Passage of the Act in 2004 was about serving, supporting, and proactively preventing adverse outcomes to clients and their families. It was not intended to fill holes in state and local funds. The diversion of $853.6 million was terrible and unanticipated. Lumping mental health services with public safety is discriminatory and fuels the media view that mental health clients are dangerous. The MHSOAC should not be welcoming the elimination of its role in providing front-end state oversight and accountability in the MHSA planning process, with particular focus on the meaningful involvement of clients and family members, unserved and underserved, without replacing that process with a comparable alternative; this would be a violation of the letter and spirit of the Act and a betrayal of those that the Commission was created to serve.

- Mr. Steven McCormick, CNMHC, asked when it was decided that the $861 million would not be paid back. Clients had been told that the $861

million was being realigned and was going to be paid back. However, he had seen today that this would not be the case. In addition, there have been changes in the language used to describe those who receive mental health services. Some of the terms are demeaning and marginalizing. Terms like "in the interest of public safety…" implies that mental health clients are dangerous, when in fact, they are usually the victims of crime and not the perpetrators. Mr. McCormick urged the Commission to adopt a stronger position, and reassure those who receive mental health services that they will be respected and consulted

- Mr. Leoni stated that we should be careful not to mix quality improvement with compliance. He encouraged the Commission to make sure that we do not step backwards and lose the cooperation of counties.

- Ms. Hiramoto commented that although change is necessary, switching to evaluation as the form of oversight was not going to be a magic pill. Data can be used against mental health clients.

- Mr. Fry commented that he would like to see a flag in the room for beginning the meetings with a flag salute. In addition, he would like to change the term "mental health" to "behavioral health" to stop the stigma.

Commissioner Poat had several comments for the record because he has to leave.

1. The Performance Dashboard has changed rather substantially this month. The evaluation timeframe should be included, as it is the heart of where we are going; it should be fleshed out to show critical junctures for accomplishing our evaluation goals. Similarly, on statewide projects, allocation of elements and a status report are very helpful to include.

   Less helpful are PEI approvals and distributions. The purpose of the Performance Dashboard is to keep MHSOAC focused on its top goals.

2. He would like to know more about Prudent Reserves and how they are being used in this financial setting. He suggested this topic be docketed for a future meeting.

3. Regarding the contract delegation being brought up later in the meeting: Commissioner Poat assumed that it was being added to the Operating Procedures, where it belongs; also, it lacked criteria and a method for notification to the Commission when certain actions were taken.

   Similarly, for authorized delegation to subordinates (Point 7), some sort of Commission notification needs to occur.

Provision 5 appears to be an elastic clause that needs to state policy clearly.

Chair Poaster pointed out for the record that no Commissioner championed the redirection of the $861 million. That action, as well as changes to the trailer bill language, etc. were the products of the Governor and the Legislature.

7. Approve Contract Signing Authority for the Executive Director

Ms. Filomena Yeroshek, Chief Counsel, stated that Assembly Bill 5xxx mandated that the Commission operate separately from the DMH. As a result of this independence, the Commission now has the direct authority to contract. To facilitate efficient operation of this business transaction, it is important to provide delegated authority to the Executive Director, so that she may act in a fairly reasonable amount of time, and not have to wait for Commission meetings.

Ms. Yeroshek provided a proposed resolution, standard for this type of delegation. She took questions from the Commissioners and addressed Commissioner Poat's concerns.

Public Comment: No public comment.

Motion: *Upon motion by Commissioner Kahn, seconded by Vice-chair Van Horn, the Commission voted unanimously to adopt the proposed contract delegation resolution, amended with language specifying that the Executive Director notify the Chair whenever the Executive Director delegates the contract authority to a subordinate.*

8. Client and Family Leadership Committee (CFLC)

First Read: Draft Policy Paper Presentation to the MHSOAC: "Transformation of the Mental Health System through Client and Family Leadership"

Commissioner Vega, Client and Family Leadership Committee (CFLC) Chair, reviewed the paper with the Commissioners. He stated that the paper was not turning out to be three pages long, but neither was it a book. It did not gloss over important details and it did not miss the opportunity for the Commission to take leadership for the state of California.

Starting last year, the CFLC has been involved in several projects to help the Commission's leadership to be informed by clients, family members, caregivers, and advocacy group members. The CFLC has drawn members from around California including rural communities and different ethnic groups. Last year the CFLC was called upon to help clarify the idea of mental health services transformation. The MHSA is a new concept. People are aware that it is

innovative and transformative, but they are not keyed in to the idea of why it is important, what it seeks to accomplish, and what is at stake.

Commissioner Vega stated that today's paper is a working draft. The CFLC was hoping to hear from the Commissioners and others on where it can be improved. The paper begins with a Background, and then includes a Summary in the middle that explains Goals for what should be happening five years from now across a transformed mental health system.

There is a focus on stakeholder input. Having client representatives and family representatives is an important element of that. Having lived-experience and people from different cultural communities actively participating in the MHSA at all levels is part of the CFLC's design, but in other parts of the country, groups are having difficulty in getting consumers to participate.

The Wellness and Recovery focus is a new theme for many. It helps to carry the vision of the MHSA for hope and motivation for recovery, enabling people to live the lives they wish to lead in the community, even while they may still be dealing with symptoms and disability.

Prevention and early intervention will be leveraged by the MHSA in California for transformation across the country. A lot of energy and resources are going into prevention and early intervention. Eliminating stigma, discarding the history of discrimination, and getting resources to people when they need them are going to transform not only the MHSA, but hopefully our society in return.

The paper covers what a transformed world will look like. Commissioner Vega believes in one definition for transformation: "Transformation represents a change in the state of affairs so completely radical as to not have been predictable from the outset." This means that we do not know exactly what transformation will look like, but we have an idea of the affected areas:

- Community planning - everyone participates
- Policymaking - California is leading the country in this
- Cultural competence and effectiveness - California must lead the way, as we have the most diverse communities of all the states
- Mental health programs
- Housing - more stability and consistency
- Employment

- Education - both employment and education go to the recovery model

- Stigma and Discrimination - statewide programs show promise

Transformation should also reach people who have landed in the criminal justice system because of homelessness or mental illness.

Commissioner Vega requested feedback on the generalities of the paper from the Commissioners and audience.

Vice-chair Van Horn commented that the introduction begins with Assembly Bill 34, but he would like to see references to statutes going back further than that. In addition, he stated that he had gone through the complete report and found it admirable.

Public Comment

- Ms. Caroline Caton, President of NAMI Sacramento and family member, commented on wording on page 2. Clients and family members need a course for transformation.

- Mr. Fry commented on stigma. He objects to the term "mental health" and prefers "behavioral health" to reduce stigma. He would like to see the term changed from the top down.

- Mr. Leoni pointed out that this is not the only paper on transformation. It would be nice to have guidance on where we're going and where we've been. The February 2005 DMH Transformation paper was recently removed from the DMH website. Mr. Leoni suggested that the MHSOAC talk to DMH and try to get other papers previously done on this topic bundled with this paper.

- Ms. Vicki Mendoza, United Advocates for Children and Families (UACF), thanked Commissioner Vega for allowing the public to have such input to the paper. She voiced concern over the effect on children who hear the labels of their illness.

- Ms. Hiramoto stated that the paper is a tremendous piece of work. Cultural competence is covered well. She asked that the Cultural and Linguistic Competence Committee (CLCC) get the chance to review the paper as a committee and she indicated that the divide between the CLCC and CLFC should be bridged. Commissioner Vega responded that he would like the goals from the CLCC work plan referenced in the paper.

- Ms. Patty Gainer, California Network of Mental Health Clients (CNMHC), complimented the CFLC on their accomplishment. She has seen more

transparency, public involvement, and cultural competency in her own county; we now expect these key elements of the MHSA. She also stated that CNMHC has produced position papers on employment.

- Mr. Vickrey was glad to have the opportunity to see this well-researched paper. He stated that often consumer input is underutilized, and hoped that wouldn't happen here.

9. MHSOAC Executive Director Report

Executive Director Gauger reported on the following items.

- She introduced the new Chief Deputy Executive Director, Aaron Carruthers.

- She brought to the attention of the Commissioners a survey in the meeting packet. It is to be sent out to stakeholders next month, who may remain anonymous when they take the survey. Staff will analyze the results, and make recommendations to the Commissioners for actual process improvements to the Commission and to the Committees.

- She shared that the four most recent fact sheets – Overview of the MHSA, Statewide Progress and Highlights of the MHSA, County Progress and Highlights, and Petris Report Findings – have all been translated into five additional languages: Spanish, Vietnamese, Cantonese, Armenian, and Tagalog. They are available on the MHSOAC website.

- In addition, the first MHSOAC report to the Legislature and Administration has now been translated into Spanish and is also posted on the website.

- She announced that the MHSA trailer bill (AB 100) has been signed by the Governor. There will be much follow-up work: roles and responsibilities need to be clarified, as does the intent. We may need to do a follow-up policy bill and Memos of Understanding between departments.

  As such, Executive Director Gauger has convened a group of Executive Directors who will meet to try to reach consensus, as a field, around some of the high-level policy issues raised by AB 100.

  Members will include:
  - Cliff Allenby, Acting Director, DMH
  - Ann Arneill-Py, PhD, Executive Officer, California Mental Health Planning Council
  - Sharon Kuehn, Director, CNMHC
  - Oscar Wright, Chief Executive Officer, UACF
  - Pat Ryan, Executive Director, CMHDA

- Jessica Cruz, Acting Director, NAMI, California
- Rusty Selix, Executive Director, Mental Health Association in California

- Executive Director Gauger noted that she had her first meeting with Diana Dooley, new Secretary of the California Health and Human Services Agency. She briefed Secretary Dooley on the activities of the MHSOAC.

- Executive Gauger took her executive team offsite for a day to do team-building, ensure focus, and prioritizing of work for the rest of the fiscal year.

10. Commissioner Comments to Identify Matters for Future Meetings

Commissioner Vega inquired about the review of the proposed DMH issue resolution process with regard to the MHSA and the MHSOAC, assigned to the CFLC about two years ago. As DMH is changing, what might be our role going forward? The issue resolution process may not unfold and be responsive.
Chair Poaster agreed that the MHSOAC has the responsibility to identify any gaps that have developed with the signing of AB 100. The MHSOAC will be looking at the development of policies and clarification of responsibilities.

11. General Public Comment

- Ms. Brody concurred with Commissioner Vega about the need to look at the issue resolution process, now more than ever. The MHSOAC is ideally suited to take the lead in establishing an open, meaningful, accountable process. She urged that stakeholders be directly involved.

- Ms. Caton suggested that we can use stronger state leadership at the community planning process level - A standardized structure, existing statewide, would be very helpful in ensuring that programs and services will reflect the needs of the community. Counties need more flexibility in how they can spend their dollars; the required 50 percent on FSPs is an arbitrary funding stipulation foisted upon each county.

- Mr. Fry commented on the issue resolution process. He supported Ms. Brody's statement. He requested that the Commission be careful in how they handle the process so that clients are not penalized.

12. Adjournment

Chair Poaster adjourned the meeting at 3:07 p.m.