

MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
May 26, 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 9:07 a.m.

He administered the oath to new Commissioner Dr. Victor Carrion, who was appointed as the representative of the Attorney General.

Chair Poaster shared a brief biography of Commissioner Carrion, who is an Associate Professor of the Stanford University School of Medicine and Director of the Stanford Early Life Stress Research Program. He is also a faculty member at the Lucile Packard Children's Hospital at Stanford. He has focused his research on the impact of early life stress on behavior and emotion, as well as the role of brain structure and function in these processes.

Chair Poaster stated that Commissioner Bray, who filled the superintendent of a school district seat, was moving on to a different line of work and different endeavors. Chair Poaster expressed his gratitude for Commissioner Bray's contributions as a fervent advocate of mental health services for children. Commissioner Poat also expressed his personal gratitude.

Chair Poaster presented a proclamation signed by Senator Correa and Assembly Member Mary Hayashi.

Commissioner Bray thanked the Commission, complimenting the members on their passion for the field. His three years on the Commission had been an incredible experience.

2. Roll Call

Commissioners in attendance: Larry Poaster, Chair; Richard Van Horn, Vice Chair; Richard Bray, Dr. Victor Carrion, Patrick Henning, Jr., Howard Kahn, Dr. Ralph Nelson, Jr., Dr. David Pating, Andrew Poat, Eduardo Vega, and Tina Wooton.

Not in attendance: Sheriff William Brown, Senator Lou Correa, and Assemblymember Mary Hayashi.

Eleven members were present and a quorum was established.

3. **Adoption of March 24, 2011 MHSOAC Meeting Minutes**

Commissioner Vega had a correction to a quote he had made on Transformation.

Commissioner Poat had a clarification to a remark he had made.

Motion: *Upon motion by Commissioner Henning, seconded by Vice Chair Van Horn, the Commission voted unanimously to adopt the minutes of the March 24, 2011 Meeting as amended.*

MHSOAC Calendar, Revised May 2011

Chair Poaster stated that a revised MHSOAC Calendar was in the meeting packet.

MHSOAC Dashboard, April and May 2011

Chair Poaster pointed out that a MHSOAC Dashboard for April and May was also in the meeting packet.

Executive Director Sherri Gauger explained that as a result of input from Commissioner Poat, reference to the number of plans reviewed and approved had been removed because the MHSOAC no longer performs plan review. The following sections were added to the Dashboard: statewide Prevention and Early Intervention (PEI) project tracking; status of University of California, Los Angeles (UCLA) evaluation deliverables; and contract information on the Reducing Disparities project.

Public Comment

Ms. Joy Torres, National Alliance on Mental Illness (NAMI), thanked the Commission and expressed the hope that the meeting goes smoothly.

4. **Financial Update**

Overview of Governor's Revised Budget for 2011-12

Ms. Kathy Gaither, Acting Chief Deputy Director, Department of Mental Health (DMH), gave a budget overview. Below are highlights of the Governor's May Revision, which contained several significant proposals:

- Creation of the new Department of State Hospitals, for long-term care services. Given the incidents of the past few months and the changes in client population at state hospitals and psychiatric programs, it became clear to Secretary Diana Dooley and the Governor's Office that a stronger focus on the state hospitals and a department with one mission is needed. It is good timing that AB 100 has been enacted to realign department activities to the local level, because we are in the process of implementing that now. AB 100 has created an opportunity to separate two missions, creating one mission with a clearer focus and better practices in the new department.

DMH will have the proposal for the new department in the January budget, and invites the MHSOAC for input on how the department should look and function.

- DMH proposed moving the portions of the Department that deal with county claims of Medi-Cal services for their mental health programs to the Department of Health Care Services (DHCS). This provides an opportunity to streamline services.

The overall goal is that alcohol and drug abuse Medi-Cal services also will be transferred to DHCS. There will be remnants of that department as well as DMH in DHCS and there has been discussion about consolidating the two departments (DMH and ADP) into something dealing with behavioral health. It is unknown at this time if this consolidation would result in a separate State department or a new division within an existing department. The DMH invites feedback from stakeholders, MHSOAC, and all who are interested.

- Due to incidents in past months, there are some safety proposals for assistance at the state hospitals to ensure the safety of both the staff and patients. These proposals include: personal alarms for staff, grounds presence teams, and grounds safety teams at Napa, Patton, and Metropolitan.

Chair Poaster asked about the timeline. Ms. Gaither replied that the decision will largely be made by November. DMH would like some time for input from MHSOAC and the public, while balancing the Governor's interest in streamlining government and ensuring that it operates efficiently as it maintains policy needs.

Vice Chair Van Horn and Ms. Gaither agreed that feedback to DMH should be given by mid-September to be considered before decisions are made.

Commissioner Poat thanked the Governor for putting this reevaluation into place and commented that although it is messy and rather difficult, it is a valuable redesign and great opportunity that was long overdue.

In response to a question from Commissioner Vega, Ms. Gaither stated that several tasks are ahead of DMH before they get to the stage of establishing organization charts. DMH is in the process of eliminating 123 positions and identifying positions and staff that need to be redirected to DHCS.

Commissioner Vega asked about the proportion of state hospital patients that are Sexually Violent Predators (SVPs). Ms. Gaither reported that 90 percent of patients in State hospitals and programs are forensic placements while about 10 percent are civil commitments. SVPs are a small number of the overall patient total, and go through a rigorous evaluation process before that type of commitment can be made.

Commissioner Henning asked about the 123 positions being eliminated. Ms. Gaither answered that they were funded with the Mental Health Services fund. Assembly Bill (AB) 100, realigned management of that fund and its services to the counties and eliminated many of the functions of the Department. The DMH is not anticipating any other staff reductions associated with the creation of the new department.

Commissioner Henning voiced his concern that people whose positions are being eliminated may have job responsibilities and knowledge that will still be needed. Ms. Gaither responded that state layoffs are done strictly by seniority. The process of demotion and displacement takes about six months.

Adopt May 2011 Financial Report

Commissioner Poat, Chair of the Funding and Policy Committee, and Tina Wooton, Vice Chair of the Funding and Policy Committee, gave a PowerPoint presentation. Below are highlights.

- Commissioner Poat noted that the reason the Financial Report is given is that twice a year, the State does budgets in which they begin to think about the revenues for the next several years. Twice a year, the Department of Finance puts out new estimates on future revenues and many policy changes occur as a result.
- A graph showing “MHSA Revenues Received or Projected (Cash Basis)” showed some good news: recovery in Fiscal Year (FY) 2011/12 and 2012/13 funds is beginning, but the bad news is that those numbers are still below FY 2010/11 funds. This is why Mental Health Services Act (MHSA) created reserve funds – to counter volatility which happens with this type of funding source (income tax on individuals who make over a certain amount of money).
- The projected MHSA revenue is based on the Department of Finance’s projection of 8.1 percent growth in Personal Income Tax, as opposed to the Legislative Analyst Office projection of 4.45 percent growth.
- Most of the money made available for Community Services and Supports (CSS), PEI, and Innovation (INN) has been distributed to the counties based on approved plans. AB 100 is causing these funds to move out more quickly to the counties.
- Counties have 10 years to spend the MHSA funds for Capital Facilities and Technological Needs because these projects take a long time to implement. We are about halfway through the ten-year period.
- Funds for State Administration are being cut from 5 percent to 3.5 percent, which increases the funds available for services.

- The MHSA Housing Program shows \$1.2 billion being leveraged by MHSA dollars. For every dollar of MHSA going into the housing program, \$6.3 dollars is coming in from other funding sources.

Commissioner Vega voiced a concern regarding the INN dollars with short-term reversion timelines. Commissioner Poat stated that he will add the INN reversion issue to the workplan of the Mental Health Funding and Policy Committee.

In response to Commissioner Henning's question about the state of the reserve funds, Commissioner Poat stated that the available data is extremely dated. Staff is currently researching the numbers and the Committee is evaluating why more current data is not available.

Public Comment

- Ms. Sharon Kuehn, California Network of Mental Health Clients (CNMHC), talked about the concerns of clients throughout the State regarding the May Revise and AB 100. The CNMHC opposes eliminating the DMH. Clients are concerned about losing the parts of the Department that have been a home, a safe house, and a support of the values that are important to them. The key message is for the MHSOAC to continue and even increase stakeholder processes.
- Mr. Donald Clark, United Advocates for Children and Families (UACF), asked questions about crucial service levels being impacted by AB 100; about the account residual balance; and about whether leveraging of MHSA housing funds has eradicated the housing needs of the homeless mentally disabled population.
- Mr. Frank Topping, Sacramento County Mental Health Board, asked about the speedier distribution of funds due to AB 100; but in which direction would the funds go and to whom?
- Ms. Torres stated concern with the budget, because looking at the budgets in her county and others, staff may not be doing a sufficient job to warrant their pay. Also, regarding housing: she has watched consumers who had received shelter plus care who ended up homeless.
- Ms. Carmen Diaz, parent and family member, asked for clarification on Medi-Cal going under DHCS. Chair Poaster recommended getting clarification from MHSOAC staff.
- Mr. Chuck Hughes, CNMHC, commented that budgets should be evaluated; just throwing money at a problem does not solve it. There needs to be oversight as well as family and consumer involvement.

- Ms. Delphine Brody, CNMHC, stated that it is essential to understand why DMH and the California Department of Alcohol and Drug Programs are so important to mental health clients. The wellness and recovery focus, as well as the community-based rehabilitative services that the DMH has overseen, could be without a state agency to oversee them and ensure that the quality remains intact.
- Ms. Linda Kaye, CNMHC, brought to the Commission's attention that many program contracts do not have clauses of accountability or termination. Programs are operating that are non-compliant in every item of their contracts.
- Ms. Rigel Flaherty, Program Manager of Second Story Care Respite House in Santa Cruz, expressed her concern about the elimination of the DMH. Providers around the State are concerned about their clients and their own jobs. People with lived experience need to have meaningful leadership positions going forward in this transformation of the mental health system.
- Ms. Hope Holland, CNMHC, addressed the elimination of DMH. The loss of its services is a grave concern. For 28 years, CNMHC has relied on funding streams from DMH that support client leadership in our state, and CNMHC would like to see that move forward.
- Mr. Joe Mortz, CNMHC, stated that we need the public policy entity of the DMH to provide leadership, guidance, and overview. He asked the Commission to preserve the DMH and the Department of Alcohol and Drug Programs. He also stated that the MHSAs dollars compared with the dollars that go into service from the federal government are different.
- Mr. Steven McCormick, CNMHC, commented that the proposed cuts to the multiple programs are very worrisome. Clients must be assured of a voice in this process; as clients we rely on all the programs that are in place to assist us in our efforts in the recovery process. We want to be productive members of our communities.
- Ms. Jennifer Bandtel, Second Story Respite House in Santa Cruz, remarked that this program had been put together with a five year Substance Abuse and Mental Health Services Administration (SAMHSA) grant. Eventually it is supposed to be client-run. She also remarked that she would hate to see any department named "Behavioral Health."
- Mr. Peter Lafollette, Ventura County Advisory Board and Client Network, commented that the Commission should know that an ongoing lawsuit against DMH is finding that implementation of MHSAs funds has a history of corruption of purpose; new Proposition 63 programs are funded at the expense of core services for people with serious mental illness. Decision makers continue to fund reports instead of results, and Proposition 63 funding goes to consultants instead of consumers.

Motion: *Upon motion by Commissioner Kahn, seconded by Commissioner Henning, the Commission voted unanimously to adopt the updated Financial Report as presented by the Mental Health Funding & Policy Committee; and to direct the Funding and Policy Committee to:*

- *Provide revised projections for MHS funding for FY 2010/11 through FY 2012/13, when available.*
- *Analyze the analysis of MHS expenditures to be provided by UCLA on June 30, 2011.*
- *Analyze the number of MHS housing projects completed.*
- *Report on prudent reserve balances*
- *Report on Innovations Reversion*
- *Report on a methodology for tracking account balances at the October Commission meeting.*

5. Services Committee Update: Prevention and Early Intervention (PEI) 2009 Trends Report

Commissioner Pating, Chair of the Services Committee, motioned to table the Services Committee discussion on the PEI Trends Report in deference to the Financial and State Travel agenda items in order to keep the meeting on schedule.

Chair Poaster encouraged the Commissioners to look at the report provided by the Services Committee.

Commissioner Pating announced that Ms. Ann Collentine, MHSOAC staff, was leaving and thanked her for her extensive work in getting out all the PEI and Innovation (INN) plans for the State and for moderating an effective review process.

6. Adopt Implementation of In-State Travel Freeze

Chair Poaster stated that the Governor had issued an Executive Order delineating travel freeze expectations for all state employees. Because this rose to a policy level, the Chair and Vice Chair believed a discussion was warranted. He urged that Commissioners understand and consider this item in the context of the current economic environment.

Executive Director Sherri Gauger reported the staff's recommendations on how to implement the Governor's travel freeze, issued on April 26, 2011. The provisions of the Executive Order include:

- Prohibition of discretionary travel.
- Executive Director approval of in-state travel.
- Governor's Office approval of out-of-state travel.

- The requirement that travel be *mission critical*: a function required by statute, contract, or executive directive.

Functions not considered mission critical are conferences, non-essential meetings that can be conducted via teleconference, networking opportunities, and continuing education classes.

Statutory requirements are from the California Welfare and Institutions Code Sections: 5845(d)(1) and 5846(c).

Staff identified three options for the Commission's consideration:

Option 1. Business as usual: continue holding all meetings as scheduled.

Option 2. Suspend all travel and conduct all meetings via teleconference.

Option 3. A compromise:

- Terminate travel outside of Sacramento.
- Hold Commission meetings in July and October or November.
- Hold Committee meetings in June, August, and October.
- The Evaluation Committee may hold additional meetings if necessary.
- Suspend Community Forums until the freeze is lifted. Staff will provide recommendations at the July meeting for how the forums may be accommodated in other ways.

Staff recommends Option 3.

Chair Poat broke down the categories of travel expenditures as Commissioners, Commission staff, and individuals the Commission enables to attend Commission activities.

Executive Director Gauger stated that it costs the Commission twice as much to be out of town as it does to be in Sacramento. Committee meetings cost about \$2,000 per meeting for travel.

Commissioner Kahn asked why a Commission meeting was scheduled in July. Executive Director Gauger responded that staff had devised a schedule with quarterly meetings – the statute said this may be done.

Vice-Chair Van Horn noted that all MHSOAC input on the future of the DMH must be provided by mid-September. He suggested a September meeting.

Commissioner Pating voiced concern that the Commission's previously approved decrease in meetings from twelve to six has hindered the ability to keep up with recent rapid changes, as well as the momentum needed for vibrant Committees.

Commissioner Kahn asked if there were anything more the Commission could do under Option 3 to meet the requirements of the Executive Order and still meet the requirements of the statute that MHSOAC follows.

Commissioner Henning expressed the belief that outreach to the community to seek its active involvement is mission critical. This includes travel to Southern California, the Bay Area, and the northern part of the State.

Executive Director Gauger explained the possible use of Webinars for community outreach.

Commissioner Nelson suggested the possibility of having two-day meetings.

Public Comment

- Ms. Kuehn shared a letter from CNMHC stating its commitment to inclusion of stakeholder voices at the Commission meetings. It believes that the Commission was formed with the intent of providing vision and leadership in collaboration with clients, their family members, and unserved communities. We are just beginning to get the voices of diverse groups – specific cultural groups who are unserved, underserved, and inappropriately served.
- Ms. Viviana Criado, California Elder Mental Health and Aging Coalition (CEMHAC), supported the petition of the CNMHC. If Option 3 were chosen, CEMHAC requested to preserve consumer forums.
- Ms. Brody asked the Commissioners to consider the letter from CNMHC, citing that client and family member participation is mission critical, as stated in MHSOAC's own mission statement.
- Ms. Abby Lubowe, Client and Family Leadership Committee and Youth Advisory Board for Humboldt County Transition-Age Youth Collaboration, commented that teleconferences are okay as supplements, but substituting them for in-person meetings does not welcome significant consumer and family participation. There is a steep learning curve. Also, in-person meetings and forums are critical for consumers and families to know that they can participate in the first place, and to know how they can participate.
- Ms. Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that REMHDCO supports the CNMHC position on this matter. For members whose first language is not English, watching body language at meetings is helpful.
- Ms. Kellie Jack commented that when MHSOAC came to Eureka, people found out that they could participate on committees. On the phone it is hard to participate – and people can not make comments. Also, traveling is difficult for people financially.

- Ms. Leslie Napper, consumer and Sacramento constituent, remarked that earlier in the meeting reducing disparities was mentioned. By adopting the implementation of the State travel freeze, you will eliminate the opportunity for agencies like the CNMHC to provide scholarships to indigent clients and consumers like her.
- Mr. Topping agreed with Ms. Kuehn and Ms. Brody. He stated that in this difficult economic environment, consumers feel that they are headed into a panic situation even resulting in suicides. He supported Option 1. This morning's difficulties with the teleconferencing line showed that this method is problematic.
- Ms. Torres stated that she works with a variety of diverse populations, including the deaf and blind. She has found that the deaf and blind are not represented in any of these oversight commissions. Translations for them are difficult during teleconferences because of lack of time. She supported Option 1.
- Ms. Cindy Robbins-Roth, a client parent, said that she was struck by the comment that publicity for MHSOAC participation is negative. Family members see MHSOAC's participation as a very positive act, showing MHSOAC's commitment to accessing family member input. Her local agency has found conference calls on a local level, seeking to reach out to family and youth, to be very limiting. She asked that if MHSOAC can not be in the communities, that they find local groups to support gatherings.
- Ms. Carmen Diaz, former MHSOAC Commissioner, agreed that it would be bad publicity for MHSOAC to stop doing local forums. That is what MHSOAC was created for.
- Mr. Clark commented that as an individual mental health consumer and a family advocate, he favored Option 3. His idea for maximizing community outreach was to involve the local faith community. In Sacramento, there are several mega-churches in the inner city, many of which have received federal Community Development Block Grant (CDBG) funding for which they are required to host community or public-oriented events. Further, many congregants have untreated mental health issues.
- Ms. Bandtel stated her support for Ms. Brody's position. She pointed out that frequently politically-based speech is fairly vague; maybe in Governor Brown's Executive Order there is some gray area. It is the MHSOAC's duty to get out and see the communities.
- Mr. Hughes agreed with Ms. Brody and Ms. Kuehn. He reiterated the point that moving meetings around the state is a great idea. Many consumers and stakeholders are at points in their recovery in which it is hard to travel outside their communities. He encouraged consideration of Option 1.

Commissioner Comment

Commissioner Pating moved to propose an Option 4 as follows.

- With the many decisions before the MHSOAC, not meeting would be detrimental to its mission. Foreseeing the direction the State was going, the Commission has already cut its meeting total this year from twelve to six. Remaining meetings would be in Sacramento. The Commission could re-evaluate the meeting schedule and locations this coming January.
- Committee meetings could be reduced with the possible exception of the Evaluation Committee, as per Option 3.
- The MHSOAC has made a non-optional strategic commitment to community forums. Perhaps the three remaining community forums could be decreased by one, and staff attendance could be reduced.

Commissioner Bray seconded the motion.

Commissioner Vega liked the thinking of Commissioner Pating on two points. First, the MHSOAC has already reduced its meeting frequency; and he felt it crucial for the MHSOAC to be a voice and a sounding board for those in communities. Second, granular cuts can be made to staff attendance at community forums. Given the current schedule of Commission meetings, we can not justify removing any of them with such issues as AB 100 and the potential restructuring of DMH at hand.

Commissioner Henning commented that community outreach is part of what is mission critical for the Commission. Possibly some community forums could be consolidated into larger Commission meetings. Meetings in different parts of the state have shown the Commissioners how vast the differences are. Possibly some of the remaining meetings could be traveling meetings involving community outreach.

Vice Chair Van Horn commented that attenuating meetings was a very bad idea. The MHSOAC is in a position where it must reach the community it is supposed to be serving. The Commission is not spending a dime of General Fund dollars in any of its work. Vice Chair Van Horn agreed that forums and meetings are both mission critical. Further, the Commission has already saved substantial money this year from what was allotted.

Commissioner Wooton stated that as a new Commissioner, it was important to be in meetings to hear from stakeholders as well as Commissioners.

Executive Director Gauger clarified that the Executive Order does not state that there will be no travel unless it is critical to the MHSOAC mission; instead it defines for the MHSOAC what is mission critical:

- Enforcement responsibilities
- Auditing functions

- Revenue collection
- As required by statute

Commissioner Pating responded that “As required by statute” is where he perceives mission critical to be community outreach.

Commissioner Vega pointed out that the MHSOAC is not a commission of Sacramento; it is a commission of the state whose duty is to the state. Community forums should be kept as originally scheduled.

Chair Poaster felt that the assertion that the MHSOAC will do nothing different was bothersome. What the Commission does should not override something that is much bigger. The Administration would not receive well an unwillingness to make relatively modest sacrifices. At DMH, 130 people are being laid off, as well as probably thousands of people in the mental health arena throughout the state.

He felt that it was an arrogant assertion that the MHSOAC is immune to a bigger reality. He did not feel that Option 4 went far enough in demonstrating that the Commission understands the very different world we are facing.

Commissioner Poat stated that the challenge was that the Commission, and more importantly, MHSA was being characterized as funding being used for travel. Proposition 63 could be repealed as quickly as it could be extended; the sustenance of the MHSA could be challenged in the current political environment. At present the Commission has to face the issue of the credibility both for itself and for the Act.

Chair Poaster concurred, and reminded the group that currently there is a billion-dollar proposal to sweep the remaining MHSA funds. He was also concerned about the staff, who would be questioned about the Commission’s action on this matter. The problem was a perception problem rather than a fiscal problem.

Commissioner Bray expressed that he is comfortable with the motion on the table, because it meets the spirit of what the Governor is trying to do, and yet it addresses the reality that the Governor is concerned about the General Fund. The Commission does not help him one cent in that; Option 4 is actually a compromise of cooperation.

Vice Chair Van Horn requested staff to look at expenses and make sure that the Commission is saving at least 50 percent of what it was slated to spend this year.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Bray, the Commission voted with seven ayes, two nays, and one abstention to adopt the following MHSOAC meeting schedule:*

- *MHSOAC Meetings in 2011: The Commission will continue to meet as scheduled for the remainder of 2011 in Sacramento.*

- *Committee Meetings in 2011: In-person Committee meetings will be held once per quarter in 2011 (June, August, and October) and the Evaluation Committee may meet more often if necessary.*
- *Community Forums in 2011: The Committee forums will be held two times instead of three times in 2011.*

7. **Assembly Bill (AB) 100 Workgroup**

Adopt AB 100 Workgroup Recommendations

Chair Poaster pointed out that this was a consensus document. People sat together for approximately 20 hours, going word by word through a set of recommendations. He encouraged the Commissioners to consider the document in its totality.

Executive Director Gauger gave a PowerPoint presentation. Below are highlights.

- The Workgroup began with the mission of reaching consensus around trailer bill language, to propose amendments to the Act. However, early on, the Legislative staff informed Executive Director Gauger that their preference was that the Workgroup operationalize AB 100. They did not want additional trailer bill language, and they did not want to open up the Act to further amendments. The Workgroup had to regroup accordingly.
- The Workgroup's agreed-upon purpose was to develop consensus recommendations around priority of the issues that resulted from the enactment of AB 100.
- The Workgroup focused its effort at a very high level, not getting into the details of how its recommendations would be implemented. There will be numerous opportunities for broader participation moving forward.
- Decisions were made based on consensus. Not everyone got exactly what they wanted, but all decided for the greater good to support the report.
- Changes to the Act that were made by AB 100 were summarized.
 - It deleted the requirement that the DMH and MHSOAC review and approve county plans.
 - The Commission, instead of the DMH, may provide technical assistance.
 - The "state," instead of DMH, will issue regulations.
 - Starting July 1, 2012, the Controller will distribute MHSOAC funds on a monthly basis to counties.
 - It reduced the administrative cap from 5 percent to 3.5 percent.

- It provided for a one-time transfer of \$862 million from the MHSAs funds for other mental health-related purposes, not subject to repayment, to be distributed in the order set forth in statute.
- Workgroup participants were Cliff Allenby, Acting Director, Department of Mental Health; Ann Arneill-Py, Executive Director, California Mental Health Planning Council; Jessica Cruz, Executive Director, National Alliance on Mental Illness, California; Sherri Gauger, Executive Director, MHSOAC; Sharon Kuehn, Executive Director, California Network of Mental Health Clients; Patricia Ryan, Executive Director, California Mental Health Directors Association; Rusty Selix, Executive Director, Mental Health Association, California; and Oscar Wright, Chief Executive Officer, United Advocates for Children and Families. and toward the end, DMH Acting Chief Deputy Director Kathy Gaither,
- The Workgroup's mission, core principles, and twelve priorities were given.
- Recommendations for each of the priorities were as follows.
 - **Priority No. 1: Identify who is the "state"**
The "state" will be determined by the Administration.
 - **Priority No. 2: Clarify MHSAs fund distribution**
 - MHSAs funds that are set forth in Component Allocations should be considered "reserved" for purpose of fund distribution for Fiscal Year 2012/13 under W&I Code Section 5891(c).
 - Component Allocations should be published for the Prevention and Early Intervention (PEI) Statewide Reducing Disparities Project.
 - The MHSAs specifically "reserves" the funds to pay for WET programs and the 3.5% administrative fund to pay the cost of DMH, MHSOAC, and CMHPC and thus these funds are not part of the unreserved funds to be distributed commencing Fiscal Year 2012/13.
 - DMH in consultation with, the MHSOAC, CMHPC, and California Mental Health Directors Association (CMHDA) should continue providing to the counties yearly estimates of the funding for each MHSAs component pursuant to W&I Code Section 5847(e).
 - County submission of the Revenue and Expenditure Report should not be a prerequisite for distribution of funds to a county.
 - The current Revenue and Expenditure Report should be either eliminated or simplified to a one page revenue and expenditure report requiring summary information by MHSAs component. If eliminated then the Medi-Cal Specialty Mental Health Cost Report should be modified to report such amounts by each MHSAs component. Whatever report is used must include sufficient information on the condition of the local MHSF and information necessary to support continued evaluation of MHSAs programs.

This report should be easy to understand and made available to stakeholders.

- Distribution of Pre-Fiscal Year 11/12 Component Funds
 - By the end of May 2011 DMH will issue Information Notice to provide a mechanism for counties to request release of all remaining pre-2011/12 Fiscal Year funds.
 - Commencing July 2011 counties will follow the procedure set forth in the Information Notice and submit a form requesting release of the Pre-Fiscal Year 2011/12 funds.
 - The State Controller upon notification from DMH that counties have submitted their fund requests will release all Pre-Fiscal Year 2011-12 funds.
- Distribution of Fiscal Year 2011/12 Component Funds (W&I Code §5892(j))
 - Counties submit Fiscal Year 2011/12 update.
 - Commencing August 1, 2011, the State Controller releases 50% of Fiscal Year 2011/12 Component Allocations to counties.
 - Commencing no later than April 30, 2012, the State Controller releases remaining Fiscal Year 2011/12 Component Allocations to counties.
- Distribution Commencing Fiscal Year 2012-13 (W&I Code §5891(c))
 - January 2012 DMH in consultation with MHSOAC, CMHPC, and CMHDA estimate fiscal year 2012/13 funding from Governor's Proposed Budget and calculate county specific component funding estimates (Component Allocations).

February 2012 DMH publishes county-specific Fiscal Year 2012/13 Component Allocations.

- March and April 2012 Counties prepare Fiscal Year 2012/13 update
 - May 2012 DMH publishes Revised Component Allocations estimates based on Governor's May Revision.
 - June 2012 Counties finalize Fiscal Year 2012/12 update and submit.
 - Commencing July 1, 2012 the State Controller releases Fiscal Year 2012/13 Component Allocations on a monthly basis.
- **Priority No. 3: Identify a mechanism to assure county compliance with MHSOAC values**
 - In addition to the annual mental health performance contract and targeted training and technical assistance, an MHSOAC state level issue resolution process can provide a mechanism to assure county compliance with the MHSOAC values.

- DMH should with input from MHSOAC, CMHPC, CMHDA, client, family members, and other stakeholders revisit, complete, and implement the MHSOAC state level issue resolution process. This process is not intended to replace current state and federal grievance and complaint processes.
- **Priority No. 4: Identify who is in charge of performance outcomes**
MHSOAC is in charge of the performance outcomes.
- **Priority No. 5: Identify process to ensure collecting and reporting comparative outcomes data and evaluation of the results**
 - DMH should continue to be responsible for collecting the data. Funds should be allocated to DMH to ensure its data collection and reporting capacity.
 - MHSOAC should be responsible for ensuring the reporting of the comparative performance outcomes data.
 - CMHPC should continue to be responsible for approving the key priority indicators and to work with mental health boards to interpret their local performance indicators.
 - Ensuring achievement and improvement in performance outcomes should not be punitive, except when a county is resistant to making improvements and requires a corrective action plan as set forth under Priority #7. There is a difference between achievement of positive performance outcomes and compliance with the statutory requirements. Training and technical assistance should be used to help counties better their performance outcomes.
- **Priority No. 6: Determine how to ensure Workforce Education and Training (WET) funds are protected**
The State must comply with W&I Code §5892(a)(1) which provides for WET funds to be in a trust fund.
- **Priority No. 7: Identify process by which higher performing counties can assist lower performing counties to improve their effectiveness**
The process for higher performing counties to assist lower performing counties to improve their effectiveness involves a multi-tier approach.
 - First, the comparative performance outcomes reports will identify the higher performing counties.
 - Second, some counties will see the higher performing counties and, without assistance, will replicate what is working well and improve their performance outcomes.
 - Third, some counties will need training and technical assistance to improve their effectiveness.

- Fourth, a few counties that, despite training and technical assistance, are still resisting improvement efforts will need to submit a corrective action plan.
 - DMH should use its statutory authority under W&I Code §5897(d) to request such a corrective action plan and the MHSOAC should use its statutory authority under W&I Code §5845(d)(10) to refer to DMH critical issues relating to performance of a county mental health program.
- **Priority No. 8: Clarify role and purpose of mental health services performance contract**
- DMH should, as required by W&I Code Section 5897(c), implement MHSA programs through the Performance Contract instead of through the current MHSA Agreement.
 - The Performance Contract should be streamlined and some of the provisions strengthened including emphasizing qualitative local stakeholder involvement in the planning process and the cultural competency requirements.
 - DMH in consultation with the MHSOAC, CMHPC, CMHDA, client, family members, and other stakeholders should determine what other viable approach is available to address the issues for which the Performance Outcome Committee, established in W&I Code Section 5611, and the Quality Improvement Committee, mentioned in W&I Code Section 5614.5, were established. Additional resources may be required.
- **Priority 9: Clarify relationship between regulations, guidelines, plans, and integrated 3-year plan**
- DMH and MHSOAC staff with input from client and family members and CMHDA take the lead to review the regulations, Information Notices, and guidelines to determine if they should be repealed, modified, or kept.
 - Section 3320 of Title 9 of the California Code of Regulations which requires counties to adopt specified standards in planning, implementing, and evaluating the programs and/or services provided with MHSA funding should be kept as is currently written. The section requires community collaboration, cultural competence, client driven, family driven, wellness recovery and resilience focused, and integrated service experiences for clients and their families as defined in Sections 3200 et seq.
 - In the future only regulations and information notices should be issued.
 - A work plan should be developed to ensure that new regulations are issued within the next year. The work plan should include stakeholder process to provide input into the proposed regulations.

- MHSOAC shall be provided an opportunity to concur with the regulations issued by the state relating to the MHSA.
- **Priority 10: Identify effective local process which assures counties will meaningfully consider stakeholder input**
 - A healthy stakeholder process should include stakeholder participation in plan development, implementation, evaluation and major budget decisions.
 - Amend regulations and reporting forms to emphasize that the local stakeholder process should be a qualitative instead of a quantitative process.
 - The language currently in the Performance Contract regarding local stakeholder participation should be strengthened to emphasize a qualitative local stakeholder process instead of a quantitative process.
 - Compliance with the local stakeholder process should be incorporated into the Performance Contract Requirements which shall include statewide standards for the stakeholder process which will be reflected in regulations and information notices to be developed.
 - MHSA Administrative funds should be used to assist in building local capacity for clients and family members to ensure the appropriate state and county agencies give full considerations to concerns about quality, structure of service delivery, or access to services pursuant to W&I Code Section 5892(d).
- **Priority 11: Identify effective process for county compliance with the law**
 - DMH should use the Performance Contract to implement MHSA programs as mandated by W&I 5897(c).
 - The MHSA County Plan including the stakeholder process should be incorporated into the Performance Contract as part of the contract deliverables.
 - The Performance Contract must be effectively monitored by the state entity charged with contract monitoring to ensure county plans comply with the law.
 - The state should use the enforcement mechanism set forth in W&I Code Section 5655 in case of non-compliance with the law.
- **Priority 12: Identify MHSOAC's role in providing Technical Assistance to counties**
 - The MHSOAC should continue to provide technical assistance for plan development when counties request assistance.

- The MHSOAC should focus on technical assistance related to identified outcomes and indicators consistent with the MHSA evaluations.
- The MHSOAC's role of providing oversight and accountability includes facilitating the delivery of training and technical assistance to county/program and providing oversight to the state entity that has the contracts with CiMH or other selected contractors to ensure that training and technical assistance includes:
 - what the counties want;
 - what clients, family members, unserved and underserved communities, and providers believe counties/programs need; and
 - what supports positive program outcomes based on research.
- The training and technical assistance contracts should stay with DMH or with whatever state entity that takes over DMH's responsibilities.
- The training and technical assistance contracts should include input from clients, family members, unserved and underserved communities, counties, and providers. To ensure this input an advisory group should be formed to assist the state to develop the priorities for the contracts. This group should include representatives of members of the AB 100 Workgroup and representatives from unserved and underserved communities.

Commissioner Nelson asked about Priority 11, regarding the performance contract for managed care: would MHSA have the same type of prescriptive contract? Executive Director Gauger responded that the Workgroup's recommendation was to take a blend of what's in existence in the MHSA agreements, and fold them into the performance contract; then take a fresh look at the whole thing to make sure it is streamlined and strengthened, particularly in regard to stakeholder processes and compliance with the law.

Commissioner Vega asked about Priority 2. Executive Director Gauger explained that the recommendation was to eliminate DMH's existing revenue expenditure report, which is cumbersome and long, and instead do a shortened DMH revenue expenditure report or use a federal Medi-Cal report.

Commissioner Wooton commented that regarding Priority 12, many counties have in-house training; also client and family members can be utilized as trainers. She hoped that MHSOAC could continue to provide training to the counties to hire consumers, in both the mental health system and the private sector.

Public Comment

- Mr. Lafollette stated that it was not a “transfer” of the \$862 million from the MHSA – it was an outright theft of the money without a valid ballot measure initiative. This Workgroup has dreamed up even more contorted bureaucratic proposals with its recommendations rather than the direct services desired by consumers and supported by families.
- Ms. Harriet Markell, California Council of Community Mental Health Agencies, commended the Workgroup on the collaborative process they had used. She pointed out that the document doesn’t really define performance outcomes. Also, requiring a county to adopt someone else’s best practice for achieving a particular client outcome really is not in keeping with the Quality Improvement spirit.
- Mr. Steve Leoni, client advocate, more or less supported the document, but had three cautions. First, he wanted the role of the performance contract to be sufficiently strong. Where there may be problems in a county, they should be monitored in real-time. Second, he cautioned not to rely too much on the issue resolution process to find things out, because many people may be afraid to speak up. Last, an effective outcome system must be in place for measurement.
- Ms. Leticia Alejandrez, California Family Resource Association and REMHDCO, talked about the process. She asked that in the future, workgroups such as this work with representatives of large constituencies of racial and ethnic communities. This is essential to develop any priorities or procedures that are culturally competent and reduce disparities.
- Mr. Jim Gilmer, commented that as a PEI evaluator, he evaluated over 30 county plans and every plan needed assistance in reducing racial and ethnic disparities. He did not see in AB 100 the compliance, accountability, or outcomes regarding racial and ethnic communities. The language needs to be inclusive. Effective stakeholder involvement is a measurable process: it can be benchmarked, processed, and contextually evaluated. As AB 100 stands now it is very vague with no timelines and benchmarks.
- Ms. Torres felt that accountability was missing from the recommendations. Programs often misrepresent their numbers. In addition, people with other disabilities are not being served correctly and many populations are being thrown into what the MHSA was all about.
- Mr. Hughes voiced a concern about terminology. “Consumer input” should be truly incorporated and not set aside. Also, there is lots of watering down of the MHSA. Holistics and the spiritual plane have not been developed.

- Ms. Lin Benjamin, California Department of Aging (CDA), commented that CDA appreciated the efforts of Rusty Selix to solicit input from stakeholders who were not included in the MHSOAC-convened workgroup. CDA was pleased with the Workgroup's recommendations. Also, with realignment, it is very important for the local stakeholders to have increased opportunities to advocate for the interests of those who are not represented.

Commissioner Discussion

Commissioner Poat asked what authorization in terms of policy objectives MHSOAC is providing to its representative at these discussions. He felt that the role of the Commission in this new environment should be established. He saw it strongly in the area of accountability, and the development and application of an accountability tool for information provided by counties, the state, and others.

He stated that the MHSOAC's long-term role in program design also needs to be established. You can not be involved in evaluation and not have an interest in leveraging the benefits of that experience in new project design. He added that Commissions should not be terribly operations-oriented; the MHSOAC should be a policy-level group.

Commissioner Vega voiced concern with what the document does not say, and felt that it contains many unknowns (e.g. the reference to qualitative rather than quantitative local stakeholder process).

Vice Chair Van Horn emphasized that the recommendations were what seven organizations were able to come to as consensus. There are many steps to go in the whole process of recasting how mental health and alcohol/drug programs are treated in state government.

Motion: *Upon motion by Commissioner Bray, seconded by Vice Chair Van Horn, the Commission voted to adopt the recommendations of the Assembly Bill 100 Workgroup as set forth in the Assembly Bill 100 Workgroup Report.*

8. Closed Session – Government Code Section 11126(a)

As the meeting reconvened, Chair Poaster reported that the Commission had met regarding personnel matters and there was no reportable action taken in closed session.

9. Evaluation Committee

Presentation: University of California, Los Angeles

Vice Chair Van Horn, Chair of the Evaluation Committee, stated that the major role of the Commission is evaluation and accountability. In pursuit of that, the Commission has entered into contracts with:

- Resource Development Associates, to take a look at what needs to be accomplished in an evaluation

- The Regents of the University of California, Los Angeles (UCLA) in partnership with Evaluation, Management, Training Associates, Inc. (EMT) around various pieces of Full-Service Partnership and other component evaluations, and examination of what is happening in PEI.

Today is the presentation of the first deliverable of the Phase II contract, regarding Community Services and Supports (CSS) from UCLA and EMT.

Dr. Todd Franke, from the UCLA Center for Healthier Children, Families and Communities, began the presentation on the report: "Summary and Synthesis of Findings on CSS Consumer Outcomes."

The report explored CSS program impact on seven domains:

1. Homelessness/Living Situation
2. Acute Psychiatric Hospitalization
3. Arrest/Incarceration
4. Physical Health Emergency
5. Education
6. Mental Health Functioning and Quality of Life
7. Employment

Findings Summary:

- Homelessness/Living Situations
 - Participation in CSS programs is related to
 - decrease in days spent homeless for transitional age youth (TAY) and adults
 - decrease in days spent in restrictive settings across all age groups, and
 - increase in days spent in independent or residential settings for children, TAY, and adults
- Acute Psychiatric Hospitalization
 - Participation in CSS programs is related to decrease in hospital episodes for mental health emergencies
- Arrest/Incarceration
 - Participation in CSS programs is related to
 - decrease in number of arrests among TAY, adults, and older adults, and
 - decrease in number of incarcerations among TAY, adults, and older adults.

Although desired trends are present, no link between CSS participation and the following domains can be made at this time due to limited evidence:

- Physical Health Emergency
- Education
- Mental Health Functioning and Quality of Life
- Employment

Methods used were:

- Key contacts
- Data sources
- Data collection period
- Response rate
- Data rendered
- Analysis

Recommendations:

1. Define a small set of consumer outcomes and indicators for data collection across counties to facilitate consistent reporting and aggregation at the statewide (system) level needs.
2. Develop statewide guidelines for analyzing and reporting consumer outcomes by age group, race/ethnicity, gender, and other important demographics to fully understand differential outcomes in an effort to address disparities.
3. Dedicate resources to providing counties with technical assistance on how best to design evaluation studies; collect and analyze data; and report, disseminate, and utilize findings.
4. Direct more resources to the rigorous evaluation of consumer outcomes across counties in the domains for which evidence is relatively sparse.

In response to a question from Commissioner Poat, Dr. Franke said that his research group had asked the counties for narrative reports that had already been completed and analyzed.

Commissioner Poat commented that most counties would probably try to be responsive and helpful, but data may not always be available or up-to-date. When funds go out, there should be clarity on turning in data.

Vice Chair Van Horn noted that there are requirements for turning in different varieties of data that the state collects, then passes to the federal government,

and so on. Dr. Franke had encountered the problem that many data sources are out-of-date because the counties have not been getting any feedback other than about Medi-Cal billing. Data may be late or non-existent.

Commissioner Kahn commented that the report was designed as a meta-analysis of sorts – a review of what’s out there. We now need to figure out what we want to know, and devise standardized ways of collecting and evaluating data.

Vice Chair Van Horn remarked that we know what we are asking for in Phases II and III of the evaluation process, but we do not yet have a sense of where we are going over the next ten years or so. We need to develop and refine a process that will make sense and provide feedback for providers.

Commissioner Carrion pointed out that the issue is not just what to look at, but how to look at it. Limitations of the data interpretations must be understood.

Dr. Franke stated that there were a lot of documents, but not many that provided concrete evidence around consumer outcomes. Commissioner Vega clarified that most of those were from Full Service Partnership (FSP) programs, which comprise about 49 percent of the CSS programs across the State – but not the sum total.

Commissioner Vega commented that one of the key components of the recovery model is quality of life; how people learn to manage symptoms and create quality of life in spite of symptoms. Dr. Franke stated that in the data they received, recovery and quality of life were combined, however, the researchers wanted to tease out quality of life data. Vice Chair Van Horn added that as the data is collected using different instruments, it can be very confusing. The data game is a serious mess.

10. Client and Family Leadership Committee

Second Read and Adopt: Draft Policy Paper: “Transformation of the Mental Health System through Client and Family Leadership”

Commissioner Vega, Chair of the Client and Family Leadership Committee (CFLC), gave a PowerPoint presentation. Below is a summary.

- At the July 2010 MHSOAC meeting, based on the Commission’s interest, the CFLC was directed to prepare a policy paper on “client and family driven transformation.”
- The paper is meant to bring clarity to:
 - The vision of transformation of mental health services
 - The relation of transformation to the MHSA
 - The role of clients and family members in transformation

- Putting clients at the fore – engaged in all levels of mental health services: planning, policy, and programming – is in itself a transformative aspect. This recognition is at the essence of transformation.
- The paper is focused on transformation of the mental health system as informed by the recovery/resiliency vision.
- The paper’s message, special areas of focus, and organization were reviewed.
- Since the March 24 meeting, numerous changes have been made in response to input. Some of the changes involved:
 - Rewriting of the Introduction
 - Incorporation of a focus on “outcomes” throughout the document
 - Identification of ways the document contributes to efforts to measure transformation
 - Frequently-used terms were clarified
 - Numerous specific additions

Public Comment

- Mr. Leoni stated that he had participated in writing the paper. He noted that many people, particularly clients, are concerned with elements of transformation that do not change over the years. An example would be counties putting mental health functioning and quality of life in the same bucket – the assumption that when you get rid of your symptoms and get better, that equates to quality of life.
- Ms. Torres commented that she is living proof that transformation can take place within recovery and wellness. She was pleased with much of the paper.
- Ms. Kathleen Derby, NAMI California, stated that her organization fully supports the paper. They want to make sure that it does not just become a paper in a file, but that it becomes a living document that we all refer to, and use as direction in how the MHSA should be enacted. She listed key elements that NAMI wanted to emphasize.
- Mr. Gilmer was pleased to see phrases such as “client-driven” and “attention to race and ethnic communities.” He encouraged the Commission to go a little deeper; any good business model revolves around the customer. That kind of commitment at the forefront will make transformation much more effective. Further, the process of transformation must be measured.
- Mr. Clark made the observation that the term “client-driven” is actually “family-driven.” If there is a problem with the nuclear family, it must be repaired. The family is the cornerstone of all human society. Also, all social organizations in

inner-city ethnic communities need to be folded into the outreach process. He added that we need to consider hip-hop culture – a vibrant, dynamic culture that's touching the entire globe.

Commissioner Comments

Commissioner Pating remarked that he sees the document as transformation through inclusion, which is very consistent with MHSA. This exists beside the co-occurring disorders vision, which is transformation through integration. The future looks toward a different form of transformation: quality in outcomes management. These papers are very important because they are policy papers staking out a ground of fuller understanding of the concepts in the Act.

Commissioner Wooton supported the paper, saying that it projects a view for so many with lived experience on what they want to see with the MHSA. The development of this paper is another method to bring a voice to those people.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Kahn, the Commission voted unanimously to approve the Client and Family Leadership Committee policy paper as presented regarding transformation of the Mental Health System.*

This paper will be included in the orientation packet for new Commissioners.

11. Amendments to MHSOAC Rules of Procedure

First Read: Proposed Amendments to Rules of Procedure

Ms. Filomena Yeroshek, Chief Counsel, presented the first read of this document, intended to support the Commission's goal to perform quality improvement on an annual basis.

During Ms. Yeroshek's review of the Rules of Procedure she identified fourteen rules that needed to be amended, and one rule that needed to be added. Ms. Yeroshek directed the Commissioners to their strike-out copy of the rules in the meeting packet.

The new rule, # 2.4, deals with documenting the Commission's delegation of contract authority to the Executive Director.

Motion: *Upon motion by Commissioner Kahn, seconded by Vice Chair Van Horn, the Commission voted unanimously to adopt the amendments to the MHSOAC Rules of Procedure as follows:*

- *The MHSOAC adopts the non-substantive technical amendments to MHSOAC Rules of Procedure, Rules 1.9, 4.8, 4.9, 4.16, and 5.4.*
- *The MHSOAC adopts the amendments to MHSOAC Rules of Procedure, Rules 1.8, 4.4, 4.13, and 5.1 which conform to statutes, regulations, and recent legislation.*

- *The MHSOAC adopts the amendments to MHSOAC Rules of Procedure, Rules 1.2, 1.3, 1.4, 1.7, and 4.6 and the addition of Rule 2.4 which conform to Commission practices.*

12. Commissioner Comments Identifying Matters for Future Meetings

Executive Director Gauger had a note from Commissioner Poat requesting a workshop focused just on evaluation, possibly in October after the September deliverable from UCLA is produced. Chair Poaster suggested setting the time for the workshop next week during the Operations Committee conference call.

Commissioner Kahn asked about the MHSOAC's mechanism for seeing how and when the PEI funds actually went out to the counties. Vice Chair Van Horn responded that once the money is released to each individual county, unless the county informs the MHSOAC on how it disburses the money to various contracts and programs, MHSOAC has no way of knowing.

Commissioner Pating added that some of this question is being looked at by the Evaluation Committee, around evaluation for PEI. As there is no more Annual Update, he wondered if there is any information that the MHSOAC could see. Executive Director Gauger responded that there actually will still be Annual Updates – but they are not necessarily submitted to the Commission for approval. The Commission could certainly request to see them.

Chair Poaster recalled that the plans required an evaluation of at least one of the PEI projects that were approved.

Dr. Deborah Lee, MHSOAC Consulting Psychologist, stated from the audience that getting an answer to the question of whether the large counties have indeed funded or launched programs would be hard to do. Currently there is no easy way; it is definitely a gap.

Chair Poaster commented that the Revenue and Expenditure Reports have a one-year lag, but the Commission could use them to begin to put together a narrative.

Dr. Lee recalled that one of the deliverables for UCLA was to look at the expenditures and implementation of all the components.

Commissioner Wooton thanked Commissioner Vega and Ms. Dee Lemonds, MHSOAC staff, for their fine work on the CFLC paper. Commissioner Vega recognized the staff and Ms. Natalie Gregory of the CFLC for their efforts.

13. General Public Comment

- Ms. Holland stated her concern that there is no Commissioner holding the seat designated for a family member of a child who has or had a severe mental illness. She then passed along a concern from Ms. Karen Hart, that

statewide and nationally, for children under the age of 18, it is not client-driven; it is family-driven/youth-guided.

- Ms. Hiramoto was glad to see the community forum reports, but commented that there was not a lot of demographic information on who attended.
- Ms. Torres commented that the quantity of service that she received when she was able to get services was a lot better than what it is now. There is no follow-up anymore.
- Ms. Robbins-Roth remarked that looking at the budget graphs, there appears to be a significant reduction in funding support for workforce and family education and training from MHSA.

Vice Chair Van Horn responded that it is a ten-year span; a lot of money was granted to the counties in the first two years. They are now on regular spending plans that will gradually reduce the balance. Chair Poaster noted that the Planning Council is the entity that tracks and follows that under statute.

- Ms. Kaye talked about the qualitative and quantitative concept. In Orange County, consumers have had workforce training. They now have an opportunity to be employed through the federal funds coming down through the Waiver, and they need HR and recovery people.
- Mr. Hughes pointed out that at ground zero where consumers get their services, the view is different. When the counties get the contracts, they look good, but when the programs are in place, consumers don't recognize them. There must be accountability because the services are not being delivered.
- Ms. Derby welcomed new Commissioner Carrion. NAMI is concerned with social justice for people with mental health conditions, especially when these people are incarcerated and treated in circumstances not necessarily beneficial to their recovery. She also thanked Commissioner Bray for his support of children's mental health. She agreed that the seat for a Commissioner who is a parent of a child who has or has had a severe mental illness should be filled soon, having been vacant for almost a year. She presented NAMI California's hope for continued open processes to address the concerns of improving the leadership of mental health in our state.

14. Adjournment

Chair Poaster adjourned the meeting at 3:54 p.m.