MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
November 17, 2011

AMMENDED AND APPROVED JANUARY 26, 2012

Department of Alcohol and Drug Programs
1700 K Street, 1st Flood Conference Room
Sacramento, California 95811
866-817-6550; Code 3190377

1. Call to Order

Chair Larry Poaster called the meeting to order at 9:17 a.m. He reviewed the agenda.

2. Roll Call

Commissioners in attendance: Larry Poaster, PhD, Chair;
Richard Van Horn, Vice-Chair; Sheriff William Brown; Victor Carrion, M.D.;
Ralph Nelson, Jr., M.D.; Andrew Poat; and Eduardo Vega. David Pating, M.D. arrived shortly after roll call.

Not in attendance: Senator Lou Correa, Assemblymember Mary Hayashi, Patrick Henning, and Tina Wooton.

Eight members were present and a quorum was established.

3. Adoption of September 22, 2011 MHSOAC Meeting Minutes

Motion: *Upon motion by Vice-Chair Van Horn, seconded by Commissioner Brown, the MHSOAC adopts the minutes of the September 22, 2011 MHSOAC Meeting.*

4. MHSOAC Calendar and Dashboard, Revised November 2011

Executive Director Sherri Gauger called to the Commissioners' attention that the financial information in the Dashboard had not been updated since July. The Department of Mental Health (DMH) had released all reserve funds in July; because of that, coupled with their limited resources, they have not kept the information current on their website. She explained that the Mental Health Services Oversight and Accountability Commission (MHSOAC) is currently in discussions with DMH, the Department of Finance, and the State Controllers Office to determine how or if they will be able to capture this information.

Executive Director Gauger also mentioned that staff is considering pulling the Regulations portion of the Dashboard until they have more current information available – the Department is presently suspending work on all of its proposed regulations.

Commissioner Poat suggested shifting the Dashboard away from a perspective of tracking procedures to a perspective of tracking service delivery and meeting goals, which would entail a different design. The shifting of the Dashboard could be a goal for next year.

5. Adopt 2012 MHSOAC Meeting Schedule

Chair Poaster stated that the Commission may wish to utilize one of the months reserved for teleconference for an in-person meeting – most likely February. He suggested for the Commissioners to look at their calendars and consider this change.

Commissioner Vega commented that the meetings are always held in Sacramento, but it means a lot for local communities to have the Commission meet around the state. He also stated that holding meetings in other counties would help to highlight both the Mental Health Services Act (MHSA) and the Commission.

Chair Poaster noted that in the Calendar before them, the provision had been made to hold two meetings out of Sacramento if the travel freeze is lifted by the Governor. Commissioner Poat commented that the Commission tries to accommodate its Legislative members by holding meetings in Sacramento while the Legislature is in session.

Commissioner Vega requested to keep this issue on the back burner and for the Commission to be thoughtful about meeting locations.

Looking at the teleconference meeting scheduled for December 27, Commissioner Poat commented that this was an inconvenient day; perhaps the December meeting could be adjusted at a future time.

Chair Poaster pointed out that per this year's schedule, a teleconference date has always been reserved in the off months should the need arise.

Public Comment

Mr. George Fry of the California Mental Health Planning Council (CMHPC) reiterated a suggestion of seven or eight months ago, that the Commission meet at some location that could connect with several rural counties.

> **Motion:** *Upon motion by Commissioner Pating, seconded by Commissioner Vega, the MHSOAC adopts the 2012 MHSOAC Meeting Schedule for January through November 2012.*

6. Elect Chair/Vice-Chair for 2012

Filomena Yeroshek, MHSOAC Chief Counsel, conducted the election. She outlined the election procedure.

Commissioner Vega nominated Larry Poaster to sit for another term as Chair. Commissioner Vega spoke about Commissioner Poaster's effective leadership and his long-standing history of partnership and engagement with the community, which serves the MHSOAC well.

Chair Poaster stated that he considers it a privilege just to be on the Commission and an even greater privilege to serve in a leadership position. He has seen tremendous growth in the Commission, and the staff; Executive Director Gauger has pulled together a fine team. There will be value in having continuity for the coming year which contains so many things coming together. Chair Poaster accepted the nomination.

> **Motion:** *Upon motion by Commissioner Vega, seconded by Commissioner Poat, the MHSOAC re-elects Larry Poaster as the Chair for 2012.*

Commissioner Pating nominated Richard Van Horn to the office of Vice-Chair. He voiced that Commissioner Van Horn has strongly represented the interests of consumers, clients, and unserved in mental health. He has worked exceptionally well with the Chair and staff in providing continuity.

Vice-Chair Van Horn stated that being semi-retired allows him the time to serve. He has enjoyed the year working with Chair Poaster and feels that they function well as a team.

> **Motion:** *Upon motion by Commissioner Pating, seconded by Commissioner Carrion, the MHSOAC re-elects Richard Van Horn as the Vice-Chair for 2012.*

7. <u>Client and Family Leadership Committee</u>

Report Findings from 2010 Community Forums

Chair Poaster stated that the forums had been identified by the Commission as an important and meaningful way to interact with the community.

Commissioner Vega, Chair of the Client and Family Leadership Committee (CFLC), gave a presentation for the Commission as summarized below.

- The Community Forums began in 2010 on a shoestring, but with a focus on the value of hearing from the community.
- In the past, when Commission meetings were held every other month in different parts of California, we had a great opportunity to hear from and meet people from all across California who had been impacted by the MHSA.
- The Community Forums were a useful way for community members to participate in policy discussion about mental health, and to be actively involved in understanding the big picture.

- As the Commission has had to meet predominately in Sacramento, it still wants to connect with communities. In particular, the CFLC wanted to have a process by which we could hear from clients and family members – who are the main stakeholders in the MHSA – about their experiences across California.
- In 2010, five forums were held. The primary goal was to hear firsthand about the MHSA, what was happening in people's communities, and how they were feeling about it.
- Ongoing issues for forums include:
  - How can the MHSOAC preserve a sense of comfort for those participating in the Community Forums? In small communities, consumers might have a complex relationship with entities such as the county mental health authority (for example, in Humboldt County); but the CFLC wants to create an atmosphere where everyone can feel free to talk and are encouraged to communicate and give useful information with no fear of retaliation or reprisal.
  - The CFLC's response for the future was to separate community program presentations from forum dialogue.
  - Community members want to know what will be done with the information they give; they have made efforts to attend the forum and share their personal opinions and do not want it to be a waste of time. The CFLC wants to get valid information, yet it is not really empowered to take specific action.
  - The CFLC's response has been to clarify its job and role, and to let people know that there were processes for issue resolution. It is important that the Commission receives enough information from the counties to make broad level determinations about things that the Commission might do in the future. The Committee has found that people in the communities of California are still looking to the MHSOAC for leadership. Last year, lessons from the Community Forums did not result in policy recommendations; it was more of a fact-finding year of developing a good process.
  - This year, the CFLC will be working on bringing information to the Commission for policy recommendations.
  - How do you get a diversity of people to attend and participate in the Community Forums? The capacity to do community outreach needs to grow.
  - The Committee will continue to expand its efforts to ensure that more stakeholders in each area are aware of events. Staff has helped greatly in this effort, as have the individual members of the CFLC.

- People have very mixed levels of information about the MHSA. Some are immersed in its planning and implementation, while some know almost nothing. The irony is that some of the people who do not know about the MHSA are involved in programs that were actually MHSA-funded.

  There is still a lack of information and misinformation about MHSA, even among those who are directly impacted by it. People do not necessarily know of its major components.

  The CFLC sometimes spent time priming the audience with basic information, so they could have useful conversations. Commissioner Van Horn has done a great job with staff creating an informational PowerPoint that is presented at the beginning of the forums.

- The 2011 Community Forums built upon the knowledge gained in 2010 to develop a structure that effectively addressed these issues. Going forward, we will have a robust Community Forum process. Commissioner Vega invited other Commissioners to participate.

- The Community Forum Planning Workgroup is now comprised of members of both the CFLC and the Cultural and Linguistic Competence Committee (CLCC).

- Commissioner Vega will continue to advocate that the MHSOAC get out to the communities more to connect with them. The Community Forums are providing an important way for people to learn about the Commission and the MHSA, and more importantly, for the Commission to learn about how people are experiencing the MHSA and its implementation.

Commissioner Questions and Discussion

Commissioner Nelson commented that he had participated in Community Forums in Visalia (a small group of participants) and San Francisco (a large group) a few years back. He had observed much positive growth in the forums since then.

Commissioner Poat asked if there are issues from the Community Forums that can be inserted into the charter for next year's Commission meetings. Commissioner Vega responded that issue resolution continues to be significant; it is important for the Commission to discern its role in this. At the end of this year, the CFLC will be bringing specific recommendations to the Commission for 2012.

Vice-Chair Van Horn noted that the 2011 forums have been jointly sponsored by the CFLC and the CLCC, which has broadened its reach.

Commissioner Pating remarked that in this world of culture change and systemic change, *how* you do things is as important as *what* you do. For the MHSOAC to seek inclusion at all levels as a goal is a transformation strategy in and of itself. He asked Commissioner Vega about strategy that leads to greater inclusion, not

just holding meetings and forums – with part of the strategy being to ensure that the counties are continuing their role of inclusion.

Commissioner Vega responded that during this process there's been feedback from the communities that they were involved in the planning process, but since then, they do not know what has materialized. They are questioning what their role can be in the MHSA moving forward.

Commissioner Pating suggested that since feedback is so essential, thinking about some inclusion metrics may be good at some point in the future.

Executive Director Gauger informed the Commissioners that pursuant to the AB 100 Workgroup Report, the DMH has convened the first meeting to revisit the issue resolution process. She was able to submit the recommendations that have come from the CFLC and the letter from Commissioners to DMH.

8. <u>Services Committee</u>

First Read: Training and Technical Assistance Framework

Commissioner Pating, Chair of the Services Committee, gave the context of the paper to be presented. In the post-AB 100 era, the MHSOAC has been looking for a new mission framed around a quality improvement cycle of which evaluation plays a central role. Being able to communicate the findings of evaluation and to improve evaluation is something the Commission will want to do.

One of the tools for this is training and technical assistance. As part of its charter, the Services Committee will be asking the Commission to adopt a set of guiding principles and framework for oversight of training and technical assistance.

Dr. Deborah Lee, Consulting Psychologist, gave a summary of the paper, as highlighted below.

- The purpose of the framework is as follows:
  - To review the statutory mandate.
  - To affirm the Commission's commitment to training and technical assistance as one of its tools for oversight and accountability.
  - To affirm important principles related to training and technical assistance.
  - To authorize the Service Committee to continue to work on this, and to return with more specific recommendations consistent with MHSOAC priorities.
- Dr. Lee reviewed the MHSA directives regarding the Commission's roles and responsibilities for training and technical assistance. The Services Committee felt that the Commission's primary contribution was high-level and big-picture to try to ensure that this resource was utilized in the best possible way.

- Dr. Lee gave a background of the MHSOAC's actions in this area beginning in 2007.
- Training and technical assistance is a tool for quality improvement, as well as part of the MHSOAC's logic model ensuring that counties are provided appropriate support in their work.
- The scope of training and technical assistance is designed to be very broad in order to give the MHSOAC maximum flexibility.
- Dr. Lee provided definitions for training and technical assistance, their principles, and intended outcomes. She explained that the framework strives to use a balanced approach where training and technical assistance is responsive to the needs of the people providing services, the people receiving the services or those who want to receive services, as well as what is known about effective training and technical assistance. Training and technical assistance is a strength based approach, not based solely on providing information, but using resources that already exist within counties and building upon this information to make it more accessible.
- Dr. Lee ended with possible priorities for action. Should the framework be adopted, the Commission would ask the Services Committee to come back with recommendations for specific priorities for action.
- Commissioner Pating reiterated that the Services Committee was offering training and technical assistance as a major oversight strategic tool, to be coordinated with the other MHSOAC programs.
- Adoption of the framework could lead the Services Committee to these starting points:
    - Develop a clearinghouse website where all of Dr. Lee's various inventories for PEI innovation could reside.
    - Look at statewide contracts for large-scale technical assistance.

Commissioner Questions and Discussion

In response to a question from Commissioner Poat, Commissioner Pating said the MHSOAC has provided training related to the plans, and that a strategic role for staff would be to report to the Commission on training taking place around the state.

Dr. Lee added that the Commission has been working closely with the California Institute for Mental Health (CiMH) on training and technical assistance; much of that focus has been on evaluation. For example, the Commission helped develop an e-learning curriculum for evaluation of Innovation programs.

Commissioner Poat expressed interest in specifics, e.g., whether there are particular topics for actions that the MHSOAC should be taking to coordinate

training being done – that could be inserted into the Services Committee's workplan for next year.

Commissioner Pating agreed, and stated that, should the Commission approve the framework, the Services Committee would begin a web-based clearinghouse, and review the statewide contracts for technical assistance, as mentioned by Dr. Lee and will also see if any specific trainings are needed for people to understand the Commission's evaluation structure as it is being built by the Evaluation Committee.

Dr. Lee clarified that the proposed motion – which the Commission would be deferring until the second read – would be to 1) adopt the framework, and 2) to charge the Services Committee to bring back those specific recommendations.

Chair Poaster noted that even though the Commission was not going to adopt the framework that day, many of the activities mentioned could proceed. Commissioner Pating commented that the Services Committee had indeed begun to explore some of them at the staff level.

Commissioner Vega asked, now that AB 100 has realigned structure to the counties, how do we know that they will actually take advantage of the technical assistance that the MHSOAC might put a lot of thought and energy into? Dr. Lee responded that the primary approach in the paper is a strength-based, positive, sharing-resources approach. Commissioner Vega emphasized the importance of the MHSOAC – in its support role – staying actively engaged in the midst of this restructured system.

Vice-Chair Van Horn noted that one of the concepts that is critically important is that evaluation, training, and technical assistance are points on a circle of growth and improvement. The Services Committee needs to explore the resources available – there are scores of foundation grants out there for technical assistance that would provide ways to fund this outside of the beleaguered state budget. We just need the charter to go out and attack these possibilities and opportunities.

Public Comment

- Delphine Brody, California Network of Mental Health Clients (CNMHC), commented that with training and technical assistance, a priority should be to ensure that client and family, as well as unserved and underserved community members are actively engaged in all of the decision-making.
- Vickie Mendoza, United Advocates for Children and Families (UACF), echoed Ms. Brody's statements, and agreed that the Community Forums and the MHSOAC meetings would be good vehicles for engaging clients and families in the area of training and technical assistance.
- Molly Brassil, California Mental Health Directors Association (CMHDA), spoke in support of a timely adoption of this framework. CMHDA would like to see

the Services Committee have the opportunity to continue to flesh out the work that's been done.

- Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), reminded the MHSOAC that at a high level, training and technical assistance was originally supposed to go to systems and partners outside of the County Mental Health. She still believed that working with partners outside the mental health community (such as Drug & Alcohol and Public Safety), utilizing the underserved community and client and family members, was a laudable goal.
- Sandra Marley, client advocate, spoke in support of the comments of Ms. Hiramoto and Ms. Brody, especially pertaining to client and family member participation. She asked about statewide contracts – did that mean county contracts or private entities?

  Commissioner Pating replied that DMH had several statewide training contracts that the Service Committee wants to inventory and review.

  Commissioner Poat commented that there is no area in which the MHSOAC operates in which forecasting is more important than training. As much as possible, one wants to be ahead of the curve rather than behind it. He asked how the Commission develops its forecasting.

  Commissioner Pating responded that we need to be constantly expanding our partnerships and that needs assessment is something that we should look at.

  Chair Poaster commented that previously, technical assistance was determined by DMH. The processes developed now, through the AB 100 Work Group Recommendations, require a much broader, inclusive group of stakeholders and organizations who will jointly do that type of needs assessment and develop the plan. We are moving from a process that had no inclusivity to one that gives everyone the opportunity to have a voice.

9. <u>Cultural and Linguistic Competence Committee</u>

Presentation: National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Will Rhett-Mariscal, CiMH and Cultural and Linguistic Competence Committee (CLCC) member, stated that the committee charter provides that the CLCC is to produce an annual training for the Commission, and they felt that this training on CLAS standards was important. He welcomed Dr. Jose Carneiro.

Below are highlights of Dr. Carneiro's PowerPoint presentation.

- CLAS was formed because the U.S. Government realized that with such a diversity of immigrants coming to the U.S., it needed an approach for treating individuals in terms of healthcare. In 2000, CLAS was officially presented to communities.
- CLAS consists of 14 standards. The core of the standards is:

  - To ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.
  - To be inclusive of all cultures.
  - To contribute to the elimination of racial and ethnic heath disparities and to improve the health of all Americans.
- The “mandates” are current federal requirements for all recipients of federal funds.
- The “guidelines” are activities recommended by the Office of Minority Health (OMH) for adoption by federal, state, and national accrediting agencies.
- The “recommendations” are activities suggested by OMH for voluntary adoption by health care organizations.
- Dr. Carneiro gave his favorite definition of culture: it represents the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies and practices “peculiar” to a particular group of people and which provides them with 1) a general design for living, and 2) patterns for interpreting reality.
- He defined the four components of culturally competence and the three components of linguistic competence.
- Cultural mapping requires that organizations know the populations they serve, more than just what languages they speak. The organizations must know the prevalent health, nutrition, and communicable diseases, as well as the values and belief systems in order to develop and provide appropriate programs and mental health services. Dr. Carneiro gave examples from a community in Guam, a Native American family, and a gypsy community.
- Dr. Carneiro recommended against having relatives serve as interpreters, because it puts everyone in an awkward situation.
- He explained the six steps to cultural competence.
- CLAS Mandate 4 requires that health care organizations provide language assistance services at no cost.
- CLAS Mandate 5 requires that health care organizations provide services in the patient’s preferred language.
- CLAS Mandate 6 requires that health care organizations assure the competence of interpreters and bilingual staff.
- CLAS Mandate 7 requires that health care organizations make available easily understood materials and signs in the patient’s preferred language.
- CLAS Guideline Standard 1 requires that health care organizations ensure that patients receive effective, understandable, and respectful care.

- CLAS Guideline Standard 2 requires that health care organizations implement strategies to recruit, retain, and promote at all levels a diverse staff representative of the demographic characteristics of the service area.
- CLAS Guideline Standard 3 requires that health care organizations provide ongoing training in culturally and linguistically appropriate service delivery.
- CLAS Guideline Standard 8 requires that health care organizations develop, implement, and promote a written strategic plan for providing culturally and linguistically appropriate services.
- CLAS Guideline Standard 9 requires that health care organizations conduct self-assessments of CLAS-related activities.
- CLAS Guideline Standard 10 requires that health care organizations ensure that patient data is collected in health records.
- CLAS Guideline Standard 11 requires that health care organizations maintain a current profile and needs assessment of the community.
- CLAS Guideline Standard 12 requires that health care organizations develop partnerships with communities and facilitate community involvement.
- CLAS Guideline Standard 13 requires that health care organizations let patients know about conflict and grievance resolution processes.
- CLAS Guideline Standard 14 states that health care organizations let the communities know about the progress they are making in implementing CLAS Standards.

Commissioner Questions and Discussion

Commissioner Poat noted that these standards apply to programs with federal dollars. He asked what happens if only state dollars are involved. Commissioner Nelson responded that the State does demand that each county have a cultural competency plan. Commissioner Vega added that there is not a scenario where a county would have only State funding. DMH has adopted CLAS and their requirements, so theoretically even if it was purely State funded they would still have to follow CLAS.

Mr. Rhett-Mariscal made the point that implementation is not easy or perfect; the question becomes the degree of implementation and improvement.

Commissioner Poat asked about the best practice today for monitoring compliance with these standards. Dr. Carneiro replied that the Office of Civil Rights is the government agency responsible for monitoring hospitals and healthcare providers; each state has one. Any complaints should be directed to this office.

Commissioner Vega commented that the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) only has authority over specific types of institutions. Small community-based providers do not have it.

Commissioner Vega asked about how we can help to ensure that these important guidelines are implemented in the context of mental health, in light of all the changes at DMH.

Commission Vega clarified that as far as monitoring compliance, there is no one agency charged with overseeing the whole; neither is there even an organized system of entities that would accomplish this. Dr. Carneiro agreed. Commissioner Nelson noted that the counties are getting the funds, and they have contractors. The counties' cultural competency plans actually cover their contractors. The State is responsible in some manner to oversee the counties.

Commissioner Pating commented about the implications for the MHSOAC: it can keep an eye on unmet needs in the state through its evaluation component – i.e., CLAS Guideline Standard 11.

Chair Poaster noted that the reason this topic had been brought forward from the CLCC is that the Commission recognizes that while the CLAS standards are critical for good services, and four of its guidelines are legal mandates for anyone receiving federal funding, we have not had the kind of response from the counties that we need for the world's most diverse society, that is, California.

Another accrediting agency that does much of California's community work is called the Council on Accrediting Rehabilitation Facilities (CARF). It has a similar set of requirements. Chair Poaster added that a good deal of the CLCC's work over the next year will include looking at implementing the CLAS standards.

Commissioner Vega mentioned the External Quality Review MediCal audit process, which should tie into the CLAS standards.

Commissioner Nelson noted that the MHSOAC should encourage the Department to act on the cultural competency plans, so the counties would at least know that what they're putting forth is acceptable. Chair Poaster agreed.

Dr. Carneiro suggested that within an organization or hospital, there should be one individual or office dedicated to cultural and linguistic competency.

10. <u>General Public Comment</u>

- Ms. Hiramoto commented that Dr. Carneiro's workshop could be connected to Next Steps for the Commission; perhaps the CLCC could check into that. She also respectfully requested that Public Comment be allowed during the MHSOAC elections. Commissioners represent the public inclusion of all. The process should be a little more transparent.
- Ms. Brody reminded the Commission that the current cultural competence planning requirements and their modification are based on the CLAS standards. Some of the CLAS guidelines need more attention, particularly those regarding community and consumer participation, the conflict resolution and grievance process, and accessibility to unserved and underserved populations. In addition to Community Forums, Commission and Committee meetings there should be a linkage to the performance contract monitor in

process as outlined in the AB 100 Work Group report. It is an accountability mechanism when looking at outcomes. This linked with implementation of CLAS standards and the State cultural competency plan requirements would make a much more integrated Training and Technical Assistance experience for the counties.

- Ms. Marley called attention to a problematic RSVP email and phone number for Modesto from a flyer connected with the CFLC's presentation. She also mentioned that California Mental Health Services Authority (CalMHSA) is having its first Advisory Committee meeting today; this constitutes a conflict of interest. In addition, she proposed that speakers of languages other than English have their own cultural centers from which to supply interpreters.
- Mr. Perry Two Feathers Tripp, CNMHC, voiced agreement with the comments of Ms. Hiramoto and Ms. Brody. He would appreciate the inclusiveness of having public comment and participation in the election of MHSOAC officers. Also, he expressed that there's a crucial need for cultural competency education and training throughout the state. Assessment tools are very important because it's a continual process in which we have to assess every program, every step, every day.

Commissioner Poat raised an issue with respect to next year's meeting schedule: there are at least two huge deliverable dates coming up next year for the MHSOAC evaluation. This will influence the type and maybe duration of meetings we would have. He requested staff and leadership to consider how to deal with this issue, as a traditional meeting format may not be the best.

11. <u>Update on the Mental Health Services Housing Program</u>

Panel Presentation – "Housing the Mentally Ill and Chronically Homeless: An Effective Solution but Counties Need Greater Flexibility"

Chair Poaster stated that as a follow-up to the July meeting presentation, the MHSOAC was pleased to welcome Nancy Vogel, author of the Senate Office of Oversight and Outcomes (SOOO) report, to give an overview of the report. After that, the Commission would hear from a panel of county mental health directors representing counties of all sizes. Following that would be a policy discussion.

Review of the Mental Health Services Act Housing Program

Below are highlights from Ms. Vogel's presentation.

- The Senate Office of Oversight and Outcomes was created in 2008 by Senator Steinberg to scrutinize government programs and publish reports about what they find.
- The review of this $400 million housing program was requested by Senator Steinberg. Fifty of the state's counties are populous enough to receive a share of the funding.

- To understand how the program was working at the ground level, Ms. Vogel talked to the people in charge of the housing program in each of the 50 counties.
- The urban, populous counties had moved most quickly to build or renovate housing.
- As of April 2011, 32 of 50 counties had at least applied to the California Housing Finance Agency (CalHFA) to use their MHSA housing funds for a specific project. At this pace, the $400 million will eventually give homes to about 2500 people.
- In some of the rural counties, mental health officials told Ms. Vogel that they lacked the staff or resources to look at this housing project. Some reported a lack of nonprofit developers in their counties who were willing to take on a small project.
- The report on the value of CalHFA to counties was mixed.
- Ms. Vogel listed common complaints of county officials. Many stated that it was difficult to invest in housing development when the demand for immediate services was so great.
- The SOOO had four recommendations:
    - Give the 11 counties that each got less than $1 million under the MHSA housing program the option, not mandate, to work with CalHFA.
    - CalHFA and the DMH should continue to grant waivers on a case-by-case basis from the rule that no more than one-third of a county's housing funds be spent on operating subsidies.
    - CalHFA and DMH should inform all counties that such waivers are possible.
    - The state should consider waiving the rule for counties that have spent at least 80 percent of their funds.
- The study concluded that this program is indeed a good way to end chronic homelessness in California, but obviously the funding isn't enough to house the total of 33,800 homeless Californians.
- Ideally, the counties with the largest populations of chronically homeless mentally ill people will continue to invest in permanent supportive housing, as difficult as that may be in the face of other budget cuts. Possibly the counties' new Joint Powers Authority will facilitate such investments.
- Hopefully, the relationships forged among developers and county housing and mental health officials will foster construction of more permanent supportive housing.

Commissioner Questions and Discussion

Commissioner Poat remarked that he would be interested to see what is happening in the context of Redevelopment going away. He explained that with Redevelopment funding, 20 percent must go to affordable housing.

Commissioner Carrion commented that there is a myth that many homeless people prefer to be homeless. He suggested that Ms. Vogel add to the report any figures of all those who have requested housing if this program were to expand.

MHSA Housing Program Opportunities & Challenges – The Experiences of Four California Counties

Patricia Ryan, Executive Director, CMHDA, reinforced the fact that from the beginning, county mental health directors have been very supportive of the need for permanent supportive housing. They recognize that it's very difficult to effectively promote the recovery of individuals with serious mental illness, if they don't have a permanent place to live.

Ms. Ryan's presentation is summarized below.

- At least one-third of the chronically homeless suffer from severe mental illness.
- Creation of permanent supportive housing is an effective way to significantly reduce chronic homelessness.
- In 2007, counties agreed to make a one-time dedication of MHSA funds to create housing for the chronically homeless. The purpose of including CalHFA was to help leverage the ability to pull down other funding sources.
- Trying to put together a policy at the state level in California that fits all 58 counties is very difficult because of the wide diversity.

Scott Gruendl, Director of the Mental Health Services Agency in Glenn County, spoke about the experience in that county as summarized below:

- After looking unsuccessfully at the new development approach, they moved to a rehabilitation approach. They finally found a six-plex in Orland; currently they are working extensively with CalHFA to complete the MHSA Housing Plan and Application. Mr. Gruendl is very concerned that they will actually be able to complete the process within the 6-month escrow.
- Some of the requirements make no sense such as the Single Asset Entity. Mr. Gruendl shared some of his ongoing concerns such as the reserve fund, ongoing administrative needs, and additional incurred costs. Once the property was found and put into escrow, the level of assistance from CalHFA has been outstanding.
- Mr. Gruendl spoke about Trinity County, which exercised the "Opt Out" option and did not assign funds to CalHFA. They had less than $200,000. Their

rehabilitated house project was initiated in July 2009 and was completed that September; clients were able to move in the following February.

Their seven-bed house has both short-term respite care and FSP housing. The ability to opt out has made a tremendous difference to them.

Rita Downs, Director of Behavioral Health in Calaveras County, spoke about her county's experience as summarized below:

- They received $739,500. Consumers were clear that they wanted their own units, so officials hired a consultant who was invaluable in teaching them about housing. DMH, CalHFA, CiMH, and the Corporation for Supportive Housing (CSH) gave a lot of assistance.
- The main obstacle in the project was finding a qualified developer. Like Glenn County, there was no Housing Authority. After five years, Calaveras County has found a nonprofit developer. This developer connected with a developer of affordable housing in an adjacent county, who found a 26-unit apartment building in a good Calaveras County site that was ready to go into foreclosure. Six of these units will be for the MHSA Housing Program. The housing won't be ready until FY 13-14.

Jim Featherstone's, retired Napa County Health and Human Services Agency (HHSA) Assistant Director, presentation is summarized below

- He showed a rendering of a 24-unit supportive housing project expected to be finished in December. He reiterated the issue that when you struggle with a major mental illness and the resulting poverty, it is nearly impossible to be healthy without a safe and consistent place to call home.
- From the MHSA, Napa County received $1.2 million for structure and $600K in operating funds. The county leveraged other funding right away, as they had done housing before.
- The hardest part of the project was working with CalHFA's requirements and expenses. The county lost money going through CalHFA that could have gone to housing – CalHFA provided assistance, but Napa County really didn't need it. The project all came together because a private group, the Gasser Foundation, is building the housing for the county; when it's complete the county will buy it back from them.

Maria Funk, District Chief of Los Angeles (LA) County DMH, gave that county's perspective as summarized below:

- The process for LA has been very different from that of the small counties. Ms. Funk gave the current program status:
  - $113.3 million out of $117.5 million has been obligated.
  - The program launched in November 2007 and by February 2009 there were enough proposals to expend all the money.

  - 21 different housing developers have built 35 projects countywide in all of LA's eight Service Areas.
  - Of 1,691 total units, 759 are MHSA units.
  - Four of 35 projects are occupied and six more will be leased in the next three months.
  - The project leveraged over $400 million of local, state, and federal funding.
- Working with CalHFA was beneficial to LA County: CalHFA could underwrite the financing, provide training and technical assistance, and advocate with other financing institutions. Other benefits were that the program has been flexible to meet the needs of the county, and all waivers have been approved; in addition, partnerships have thrived.
- Ms. Funk showed photos and artist renderings of many of the projects, and provided details about them.

Commissioner Questions and Discussion

Chair Poaster recalled the saying, "When you've seen one county, you've seen one county." He commented on the struggles, energy, and effort that people have put into this program, and noted that it is just one of the six components of the MHSA.

Vice-Chair Van Horn remarked that there are a number of projects around the state that started under the impetus of the MHSA's initial $400 million. Several hundred more units have been developed around the state because this project was going forward, and people found other ways to finance: profit to nonprofit and partnership/shared ownership.

Public Comment

- Steve Leoni, consumer advocate, commented that this program points out how much California has not had the infrastructure to take care of this program; and that California's real estate market has failed – a person on SSI cannot get middle-class housing. One of the roles of the Commission is to advocate to the Legislature to look at affordable housing.
- Ms. Brody commented that although she was thrilled to see housing take off in counties of all sizes, she hoped that the voices of clients and family members, unserved/underserved communities, and people who have lived in supported housing can be included in the design of these programs. One of the trends she sees in the largest cities is congregate, clustered housing – yet this isn't the only model. There is also mixed use and single unit housing.
- Ms. Marley asked who does the oversight for CalHFA; Ms. Downs responded that since it is a State agency, the Governor would be responsible. Ms. Marley noted that CEO incomes for Freddie Mac are currently being

limited in Congress, and she hoped that CalHFA incomes did not get out of hand like that.

- Mr. Gruendl addressed a question about redevelopment agencies (RDAs): what are they going to be moving forward? He answered that there are three quick responses.

    1. There will be variance because the law allowed communities to either dissolve their RDAs or continue them. For those communities continuing their RDAs, they will have about 1/3 of the money as formerly because of cuts to agencies no longer being funded by the state General Fund.
    2. Because we thought RDAs were going to be abolished, projects that normally would have been approved and developed over a five-year period were approved over a five-week period. Every last penny is now dedicated for a number of years, including non-MHSA projects.
    3. Because the funding is so diminished, the ability to have sufficient revenue to pass bonds to do the level of housing we need is significantly limited.

- Anne Cory, CSH Director of Northern California Programs, commented that it's important to point out that the technical assistance provided to counties has evolved over time, and has been heavily impacted by the economic downturn. Where counties thought that MHSA rules were inflexible, they were in fact very flexible; the counties just needed to learn more about it. Housing development is hard and it is slow, particularly in the smaller counties where they don't have the time or resources to learn about it.

  CSH has already started developing training materials on how to move people out of supportive housing to other independent living when they have stabilized and are ready. Ms. Cory hoped for an opportunity to continue working with the MHSOAC as this program evolves.

Commissioner Questions and Discussion

Commissioner Brown asked to what extent this housing is available to the formerly incarcerated who also have mental illness. Ms. Vogel believed that the rules may exclude felons. Ms. Funk responded that they do not exclude those coming out from incarceration – they just have to be homeless. Some may not get through the screening if the housing is subsidized by Section 8.

Ms. Downs commented that MHSA prohibited using its dollars to pay for parolees when they were considered to be state responsibility parolees. With Realignment and AB 109 transition, parolees may be considered to be members of the community.

Commissioner Brown established with Ms. Funk that non-felons on probation can be served. She informed Commissioner Brown that in LA County, the two things that will always exclude a person from subsidized housing is a conviction for

methamphetamine manufacturing or registered sex offenders. This varies by Housing Authority and by county.

Commissioner Pating noted that the national model is "Housing first." He did not feel a need for the Commission to test the model or prove the model. In addition, other panels have shown that of $300,000 million that we have put in, we have gotten $1 billion in leverage. In terms of individual units, he had priced it out at $168,000 per unit – with this being a model program, we don't know if that's satisfactory or not.

The same is true with client and system outcomes; for FSP data on clients who were 100 percent State housed, we could show some system outcomes. This is also true regarding flexibility. What would be the goals in allowing more flexibility? Context is needed.

Chair Poaster stated that his intent would be to bring this back in a way that specifically addresses the recommendations in the report, plus any other action items that the Commissioners would feel appropriate.

Commissioner Poat agreed that the Commission needs to define the environment in which decisions are going to be made moving forward.

12. <u>Evaluation Committee</u>

Recommendations for $875,000 in FY 2011/12 Funds for Evaluation

Vice-Chair Van Horn, Committee Chair, stated that they are now at the point to decide on the recommendations for expending the evaluation funds, which need to be committed.

Executive Director Gauger provided the Commissioners with an overview of the process used to establish the priorities for the $875,000 in evaluation funds. She also gave the Evaluation Committee's recommendation.

Below are highlights of the overview.

- Last year the Legislature appropriated annual funding to the Commission for the purpose of conducting ongoing MHSA evaluations.
- Several months ago the Evaluation Committee and staff agreed to an approach they would use to prioritize those annual evaluations.
- Staff and subject matter experts met in September to narrow the priorities that the Evaluation Committee had identified. The resulting priorities are as follows.
    - Proposal C: Assess Impact of Early Intervention Programs.
    - Proposal E: Design MHSOAC PEI Evaluation Strategy (Jointly with CalMHSA).
    - Proposal F: Regional Learning Collaboratives, Initially for County DCR Data Validation and Use.

  - Proposal G: Summarize Existing Reports and Information Regarding Impact on Mental Health Disparities.
  - Proposal H: Statewide Support for County Data Collection and Reporting System (DCR) Data Validation and Use of Reports.
  - The Committee also strongly believes that a master plan for evaluating mental health services needs has to be developed in 2012. (Not a part of the $875K proposed priorities.)

- The proposed motions are:
  - For the Commission to adopt the Evaluation Committee recommendations of the priority proposals to expend the $875,000 in FY 2011-12 funds for evaluation: Proposals, C, G, and H.
  - For the Commission to approve the CalMHSA proposal, which would incorporate CalMHSA's evaluation contract with RAND Corporation, the creation of a statewide evaluation framework for PEI. The framework would also include the three areas that are the focus of the CalMHSA statewide projects. MHSOAC would be closely involved with the development of the framework, and the Commission would approve it.

Commissioner Questions and Discussion

In response to a question from Commissioner Poat, Vice-Chair Van Horn stated that the results of the vote were a Committee consensus.

Commissioner Vega asked about how to make sure the Commission is getting information now for building a structure to look at the impact of PEI. Vice-Chair Van Horn responded that there is an ongoing commitment of $1 million. The anticipation is that we will then begin to discuss with the Legislature and the Administration ways to ensure that over many years, there is continuous evaluation money available.

Commissioner Vega asked about evaluation projects as they come forward – will we be using some kind of community participatory evaluation structure? Chair Poaster answered that this would be integral to the entire evaluation process.

Commissioner Vega ascertained that the Commission will be talking with contractors about quality of life indicators, success indicators, and so on. Vice-Chair Van Horn noted that the federal government has a project national outcome measurement system which the Evaluation Committee will examine much more closely and probably conform to. It entails significant amounts of consumer and family input.

Chair Poaster pointed out that the Commission cannot overlook the fact that there are indicators and outcomes identified in the Statute.

Commissioner Pating commented that to say that all evaluations should be participatory would be an overstatement – but that method must be included and incorporated in contracts.

Commissioner Vega stressed the importance of including that piece – of community participation in research development – in RFPs and in the structure going forward.

Chair Poaster asked about Proposal C: PEIs are not really one single thing; there are prevention activities and early intervention activities. Vice-Chair Van Horn agreed that this proposal is really about early intervention. Chair Poaster suggested separating PEI into Prevention versus Early Intervention.

Public Comment

- Mr. Leoni voiced disappointment about the proposals that did not make the final cut. They are also of great value, but obviously there just is not enough money to do everything. He suggested a proposal to look at how the counties are using their own evaluation processes and making improvements.

  Mr. Leoni also mentioned that a million dollars is inadequate to the critical nature of this task. There needs to be an assessment of what is being spent around the state by all the counties, coordinated and uncoordinated. The role of this Commission and the State in general need to be established. If the amount of money needs to be beefed up, a campaign should be taken to the Legislature.

- Ms. Hiramoto thanked the Evaluation Committee for including Proposal G for addressing the impact of mental health disparities. She stated that the California MHSA Multicultural Coalition (CMMC), part of the Reducing Disparities Projects, is very interested in collaborating with the MHSOAC.

- Stephanie Welch, CalMHSA, thanked the Evaluation Committee and staff for their interest in working with CalMHSA to develop a framework a PEI contract with the RAND contract. She provided a background for how CalMHSA planned to use the process. She also recommended the use of regional collaboratives to get people who use DCR data to inform their practice, and to look at other ways to analyze it – a quality improvement activity.

- Ms. Brassil made the key point for CMHDA that while all the proposals are valuable, they are only as valuable as the accuracy of the data to produce outcomes. CMHDA seeks a long-term approach to looking at how we do evaluation of mental health.

  Vice-Chair Van Horn agreed about the concern for quality of data. There's only so much money this year, and we need to know more about what is going to happen with DCR in the future. We are doing all of this in ranges because we don't have the answers right now.

- Ms. Marley noted that all of this evaluation and oversight is so important for the MHSOAC. From the very beginning we wanted to establish client/family feedback and transparency. Association with other agencies gets the Commission far away from the client/family.

Commissioner Poat agreed with Mr. Leoni's comment: it would be very helpful for staff to retain the two proposals that did not make it into the recommendation, for future consideration. He also remarked that with this huge task, we'll have to accomplish it using various steps. It will be helpful to frame the different steps in terms of data and evaluation, in a layout with assigned budget years.

Vice-Chair Van Horn responded that this will be the Evaluation Master Plan that the Commission's research scientist will spend a good portion of his first year developing.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Poat, the Commission voted unanimously to:*

1. *Adopt the Evaluation Committee recommendations of the priority proposals to expend the $875,000 in FY 2011/12 funds for evaluation as set forth below:*
   - *Proposal C: Assess Impact of PEI for Individuals with Serious Mental Illness and their Families*
   - *Proposal G: Summarize County Reports on Impact on Mental Health Disparities*
   - *Proposal H: Statewide Support for County Data Collection and Reporting (DCR) System Data Validation and Use of Reports*

2. *Approve the CalMHSA proposal to:*
   - *Incorporate into CalMHSA's evaluation contract with RAND Corporation, the creation of a statewide evaluation framework for PEI that includes all MHSA specified negative outcomes as a result of serious mental illness (suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes) populations across the lifespan, and areas of focus, both prevention and early intervention. The framework would also include the three areas (stigma reduction, suicide prevention, and student mental health) that are the focus of the CalMHSA statewide projects.*
   - *Have MHSOAC (staff and/or Evaluation Committee members) closely involved with the development of the framework; and*
   - *Have the framework be approved by the Commission*

Evaluation Committee

Presentation: Summary of Available Prevention and Early Intervention Evaluations

Vice-Chair Van Horn, Committee Chair, stated that the Commission had one more deliverable from UCLA. Dr. Todd Franke, principal investigator for the entire UCLA contract, presented the report, entitled "Summary & Synthesis of PEI Evaluations & Data Elements" as highlighted below.

- The purpose of the report was to summarize previous and existing PEI evaluation efforts by counties, providers, academic institutions – any data that was available in the counties that related to PEI.
- Dr. Franke explained the following:
  - Methods for obtaining data
  - Data sources and quantity of available data.
  - PEI intended outcomes.
  - Content and quality of local evaluation plans. Because of overall inconsistency across the counties in terms of content and plan quality, and lack of clarity and specificity, the investigating team made three recommendations:
    - Establish overall evaluation goals for PEI.
    - Provide counties with support and technical assistance on designing evaluation studies.
    - Provide counties with guidance to identify and collect outcomes data on the family, program, and system levels.
  - PEI data elements. The recommendation was to ensure that counties understand how to use process-oriented data to help interpret program outcomes.
  - Individuals served in PEI. The recommendations were to have counties report separately the actual number of individuals served across prevention programs, the actual number of individuals served for early intervention program, and the estimated number of individuals served in prevention programs; and to provide guidance to counties on how to report the number of individuals served across PEI programs.
  - PEI reported outcomes. Dr. Franke gave a summary of the results. Recommendations were:
    - Provide counties with resources, guidance, and technical assistance for reporting.
    - Develop a reporting format for PEI evaluation findings.

- Statewide analyses on PEI should group counties based on the type of projects they have chosen for their local evaluation.
- Help counties identify appropriate program/system level indicators.

Commissioner Questions and Discussion

Commissioner Poat asked whether there was a common motivator for counties that had quality data. Dr. Franke replied that it seems to be the larger counties: they have more resources, or they have the availability to leverage resources to produce reports with higher utility.

Commissioner Poat asked about change management – what was the nature of the cultural change that was involved? Dr. Franke responded that lots of counties are collecting a lot of great information; the challenge is what to do with it and how to present it. That is why the technical assistance recommendation was scattered throughout the report.

Vice-Chair Van Horn asked about the recommendation to establish overall evaluation goals for PEI. Would you see this coming about via the upcoming collaboration with RAND on PEI evaluation framework? Dr. Franke said that could potentially be a result.

Vice-Chair Van Horn noted that very few counties have done much implementation yet. Dr. Franke agreed, and felt that this will change over the years. When the investigating team requested data from the counties this summer, every county did respond with something.

Commissioner Pating asked what Dr. Franke could give the Commission as Next Steps, as most of the information in the report was already known. Dr. Franke responded that the research team could not give much more specificity. The project data collection had not involved getting new information from the counties, but using and pulling together all data that the counties had available, and summarizing strengths and weaknesses. It is clear that many of the counties need support in thinking about how to implement and undertake their evaluations.

Commissioner Poat commented that the report helped him understand the nature of the culture we're moving into when we start this data-driven evaluation system. Vice-Chair Van Horn agreed, and noted that it shows the underlying need for a total PEI framework. Dr. Franke commented that there needs to be some training and capacity-building happening among the counties. They are clearly willing to get better at this.

Vice-Chair Van Horn remarked that we allocated $6 million/year for four years for PEI training in evaluation, programs, etc. It is clearly not producing the results we want right now. We need to track what happened to that money in the counties – do they need to give it back?

Commissioner Nelson asked whether the research team had encountered counties that had good systems that would work in other counties. Dr. Franke

replied that several counties had set up systems that seem to be working well, but again those tend to be the larger counties. When you start trying to build evaluation capacity, it comes down to providing training to people. Sometimes after people receive training at an agency they move on to work for someone else, taking their evaluation skills with them.

Commissioner Carrion asked whether it would be possible for the Evaluation Committee to describe a data collection protocol that could be applied to different counties. Dr. Franke replied that it would be possible, but it would be worthwhile to work with the counties on what that protocol might be.

Vice-Chair Van Horn felt that what we are asking from our researcher in this first year – overall PEI evaluation framework – will give us the grist to discern what we need to do for training and technical assistance, as well as what selected group of data elements should be applied to PEI programs statewide versus evaluation of particular local needs. This information will move us ahead.

Commissioner Poat pointed out that the County Boards of Supervisors influence county budgets. The Commission needs to come up with an approach for resource allocation associated with goals.

Commissioner Pating asked whether there is capacity under Dr. Franke's contract for a follow-up report. He replied that they are heading into looking at priority indicators that they have identified, some of which will be relevant to PEI. They have many deliverables coming up in the next 18 months, almost every quarter. The Commission can certainly give the researchers a different charge if they wish.

Public Comment

- Catherine Bond, Los Angeles County Clients Coalition (LACCC), touched on the cultural complexities of LA. The county has 13 target languages they need to address when offering treatment. LACCC received funding for a strategic objective: training called "Innovations in Recovery." Ms. Bond was critical of the MHSOAC Best Practices list for not having anything to do with client-run or peer-run programs.
- Mr. Leoni addressed the chaos in the counties regarding data measurements. The issue had to do with the whole Realignment impetus: Let the counties do what they need and want to do. However, there needs to be an underpinning of consistency. Mr. Leoni hoped the Commission would commit itself to a narrative process with the counties (and other stakeholders) on what this underpinning should look like. He used an analogy of roads – the county decides where to build its own roads, but roads are consistent across the state from county to county.

13. <u>MHSOAC Executive Director Report</u>

Executive Director Gauger gave the report as summarized below.

- The Quality Improvement (QI) Survey had been completed. Its objective was to obtain constructive feedback on what the Commission is doing well, and what could be improved.
  - The survey, comprised of 25 questions, had been conducted online in April 2011. There were 210 responses.
  - Ratings of the Commission were more positive than negative. The staff and website received high ratings. MHSOAC committees received neutral ratings in regard to their effectiveness to serve as a forum of advocacy.
  - Suggested improvements were clarification of the MHSOAC's role; strengthened dissemination of information; and improvement of advocacy through greater stakeholder inclusion.
  - A second survey is planned for 2012.
- The first AB 100 Regulations meeting between DMH, MHSOAC, CMHDA, and stakeholders took place in October. Executive Director Gauger recommended that to the extent that prior approvals were provided by the Commission, she will bring back any changes to the Commission for subsequent approval.
- Jennifer Whitney, the new MHSOAC Public Information Officer, has started developing a Media Plan/Strategy regarding Prop 63. As part of the strategy, Ms. Whitney began the facilitation of a Media Workgroup. Other strategies are:
  - Develop a brand for Prop 63.
  - Develop a new website dedicated to Prop 63.
  - Created a Facebook page for Prop 63.
  - Created a Twitter account for Prop 63.
  - Create a smart phone application.
  - Compile a regional crisis list.
  - Film a video consisting of Prop 63 success stories.
  - Identify stories to be pitched to television/radio/print.
  - Continue to write Op Eds.
- At the September meeting, the Commission passed a motion to support the proposed revised calculation of Innovation Reversion and sought out support from DMH. Director Allenby subsequently offered DMH support. After agreeing on the approach with CMHDA, MHSOAC staff, and the fiscal consultant, DMH drafted a notice to send to the counties.
- Staff will be preparing an Innovation Trends Report for the Governor and Legislature. The report is primarily an analysis of the 86 Innovation program

plans approved by the Commission. The report also takes a brief look at 48 Innovation plans from 22 counties approved locally after the passage of AB 100. Executive Director Gauger described report highlights.

- Executive Director Gauger continues to be in contact with the Governor's Office approximately every two weeks on progress for filling the vacant Commissioner seats. The Governor's Office and MHSOAC staff are doing targeted outreach.
- The next Community Forum will be held in Modesto on December 8.

Commissioner Poat inquired about the words used in the QI Survey to evaluate committee experiences regarding providing "helpful information." He didn't feel that the MHSOAC committee system is designed for that. Executive Director Gauger agreed, and noted that the survey is being redesigned and reworded for 2012. Commissioner Poat also advised against using the word "advocacy;" committees are a place for information sharing.

14. General Public Comment

- Ms. Bond stated that in Los Angeles County, clients are concerned about the increased evaluations of children at younger and younger ages with the assumption that prescribing psychotropic drugs – tested on adults short-term – can safely be given to children, possibly long-term. She hoped the Commission would take up this cause.

  Vice-Chair Van Horn responded that the Commission would carry it forward to the authorities in Sacramento.

- Ms. Hiramoto apologized that in her statements earlier regarding the MHSOAC election, she had used an inappropriate choice of words. She also thanked the Commission for its past support of stakeholder involvement when negotiating with CalMHSA on its administration of the statewide PEI grants. With continued vigilance and advocacy, the stakeholders were able to convince CalMHSA to develop a stakeholder advisory committee.

  Ms. Hiramoto expressed concern about possible conflict of interest in the membership on the CalMHSA Advisory Committee. She also pointed out that the CalMHSA Advisory Committee had their first meeting today as well, creating a scheduling conflict for those who wished to attend both the MHSOAC and CalMHSA meetings being held today.

- Mr. Fry commented that at last month's meeting of the CMHPC, several members had gone to the offices of the Legislature, and found that they are clueless about the MHSA. Information needs to be disseminated to them.

15. Adjournment

Chair Poaster adjourned the meeting at 4:42 p.m.