



**Trial Balloon for MHSOAC Work Plan,
Draft 4**

January, 2007 through June, 2008

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Introduction

The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in July 2005. The role of the MHSOAC is a complex one. The MHSOAC creates a vision of a transformed system and holds State and County Departments of Mental Health accountable for achieving that vision. The Commission recommends policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the Mental Health Services Act.

This is an eighteen (18) month Work Plan from January 1, 2007 through June 30, 2008, which spans FY 2006/2007 and FY 2007/2008. It is intended to be a blueprint to satisfy all of the above stated objectives. It proposes an MHSOAC mission; it defines the MHSOAC core roles and responsibilities, as specified in the Act; identifies Commission goals consistent with the Act, spells out long-term strategies and short-term activities; and, suggests an organizational structure to fulfill the Commission's responsibilities and implement its strategies.

Throughout, *the MHSOAC Work Plan* includes the themes of moving the system to one that is client- and family-driven and culturally competent, attempting to reach underserved communities and emphasizing positive outcomes for Californians with mental illness. It also emphasizes the need for all of California's mental health stakeholders to work collaboratively in order to change individual lives and improve communities.

Proposed Mission Statement of the Mental Health Services Oversight and Accountability Commission

Provide the vision and leadership, in collaboration with clients, their family members, and underserved communities, to ensure Californians understand mental health is essential to overall health; and to hold public systems accountable and provide oversight for eliminating disparities, promoting mental wellness, recovery and resiliency and ensuring positive outcomes for individuals living with serious mental illness and their families.

MHSOAC Role and Responsibilities (as defined by the MHSA)

1. In collaboration with clients, family members, and underserved communities, provide the vision, leadership and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, care and support to California's living with mental illness.

Principles essential to this transformation include:

- Reduce the risk of adverse outcomes of mental illness in children, youth, adolescents, adults, and older adults
- Foster and expand consumer and family involvement at all levels
- Expand interagency-governance, collaboration, and integration to provide a seamless, holistic, and comprehensive system of care
- Establish comprehensive outcomes to meet the full set of individual and family needs
- Promote wellness, facilitate recovery and build resilience as standards of care in all practices and services
- Promote cost effectiveness and efficiency as standards of care in all practices and services
- Eliminate racial, ethnic, gender, income, age, and geographic disparities to access, quality of care, and outcomes
- Foster open and timely communication with Californians about progress made transforming mental health services.
- Increase public policy and commitment, and community capacity to appropriately serve all people with mental illness

(MHSA, Sections 2, Findings and Declarations; 5845 a-d)

2. Oversee the implementation of MHSA Parts 3 and 4, Community Services and Supports (Adults, Older Adults and Children System of Care); Part 3.1, Human Resources; Part 3.2, Innovative Programs; and Part 3.6 , Prevention and Early Intervention Programs. Hold the State and County DMH accountable for developing and implementing transformative programs.

(MHSA, 5845 a)

- Provide review and comment on the Community Service and Support, Capital and Information Technology, and Education and Training MHSA components
- Review, comment and approve expenditures in MHSA County as well as Statewide Plans for Prevention, Early Intervention, and Innovation.

(MHSA, 5846 a, 5847 a-b)

3. In collaboration with clients, family members, and underserved communities, develop strategies to combat and overcome stigma. **(MHSA, 5845 d.5)**
4. Advise the Governor and/or the Legislature regarding actions the state may take to improve care and services for individuals experiencing mental illness. **(MHSA, 5845 d. 6)**

5. Ensure transparency of the Mental Health Services Act in planning, implementation, and outcomes. **(MHSA, 5845 d. 4, 5, and 6)**
6. Develop additional and necessary strategies to accomplish any objective or provision of the MHSA. Include clients, families, and underserved communities in development of strategies. **(MHSA, 5845 d.7)**

MHSOAC Goals

The MHSOAC is responsible for ensuring the intent and purpose of the MHSA are achieved. In particular, the MHSOAC has statutory responsibility over plan expenditures in what can be considered the MHSA components that are key to mental health systems transformation. Therefore, the MHSOAC is establishing the goals of the Commission in alignment with the goals of the Prevention, Early Intervention, and Innovation programs.

It is the goal of Prevention, Early Intervention, and Innovation to ensure specific outcomes occur for children, transition age youth, adults and older adults living with mental illness, in particular those from underserved communities. Therefore the goals of the MHSOAC Work Plan are to ensure that California counties and the State Department of Mental Health are accountable for the following outcomes identified in the **MHSA, section 5840, section d. (1-7):**

1. A reduction in suicide (Individuals living with mental illness are safe)
2. A reduction in incarceration (Individuals living with mental illness are living in the community with access to “help first” care)
3. A reduction in school failure (Individuals living with mental illness are succeeding in school)
4. A reduction in unemployment (Individuals living with mental illness are employed and earn a living wage)
5. A reduction in prolonged suffering (Individuals living with mental illness have friends and perceive themselves as living in a supportive community)
6. A reduction in homelessness (Individuals living with mental illness are in independent or supported living situations)
7. A reduction in removal of children from homes (Individuals living with mental illness are living with families and experience consistency, support, and love)

MHSOAC Strategies

KEY STRATEGIES

The MHSOAC will adopt 4 (four) key strategies to fulfill its roles and responsibilities and achieve its mission. Key strategies remain consistent from year to year. The 4 (four) key MHSOAC strategies being proposed are:

- I. Ensure Transparency of Mental Health Services Act through Communication with and Education of the Public
- II. Provide Oversight over the Mental Health Services Fund and Ensure Accountability to the Intent and Purpose of the Mental Health Services Act by:
 - a. Reviewing and Providing Comment on Community Services and Supports, Education and Training, and Capital and Information Technology MHSOAC County Plans. For these plans, provide transformation principles and implementation strategies to DMH to include in Local Plan Requirements
 - b. Assisting State Dept. of Mental Health in developing County and Statewide Plan Requirements for Prevention, Early Intervention, and Innovation; Review, Comment, and Provide Final Approval on County and Statewide Plan Expenditures in Prevention, Early Intervention, and Innovation Plans
- III. Establish Expectations for Statewide Outcomes Accountability
- IV. Develop and Advance a Statewide Policy Agenda that Promotes Systems Transformation

Activities to Implement the Strategies: January 2007-June 2008

I. Ensure Transparency of Mental Health Services Act through Communication with and Education of the Public (MHSOAC Roles 1, 3 and 6)

MHSOAC will prepare for the Governor, Legislature, State and County departments, stakeholders and the public a variety of accountability reports that highlight the positive impacts, new opportunities, and challenges resulting from MHSA.

Activity

1. Establish process for public reporting on the Mental Health Services Act Fund estimate and policy issues related to the fund revenue. (2nd quarter, FY, 06-07)
2. Write “State of California’s Mental Health Report” a well-documented, clearly written, and coherently constructed report about the current state of California’s mental health system and impacts of MHSA since the legislation passed in November 2004. (4th quarter, FY 06-07)
3. Communicate the key components of this report and other key issues as identified by the Commission to the public via newspaper, radio, speaker’s bureaus, etc. (4th quarter, FY 06-07)

II. Provide Oversight over the Mental Health Services Fund and Ensure Accountability to the Intent and Purpose of the Mental Health Services Act (MHSOAC Roles 1,2,4,5, 7)

- Community Services and Supports, Capitol and IT, Education and Training
Provide transformation principles and implementation strategies to DMH to include in Local Plan Requirements/Regulations. Review, provide comment, and provide oversight over expenditures in County Plans on Community Services and Supports, Capital and IT, Education and Training.

Activities

1. MHSOAC will review and provide comment to ensure the requirements in CSS Annual Updates include transformative principles. (1st quarter, FY 06-07)
2. MHSOAC will review and provide comment on California Counties FY 06-07 Community Services and Supports Annual Updates. (3rd quarter, FY 06-07)
3. MHSOAC will establish and communicate to mental health stakeholders, local and state agencies, and the broader public its framework of transformation principles and implementation strategies for the CSS Integrated Plan. These Plans include Capital/IT. (4th quarter, FY 06-07)

4. MHSOAC will use this framework establish local plan review, comment, and oversight procedures for FY 08-09 CSS Integrated Plans. (2nd quarter, FY 07-08)
5. MHSOAC will report to the general public the progress being made by Counties in transforming their service system and achieving outcomes. (4th quarter, FY 07-08)

■ **Prevention and Early Intervention (PEI):**

The MHSOAC will ensure the implementation of Prevention and Early Intervention Plans are consistent with the mandates of the MHSA, approve final Prevention and Early Intervention Plan requirements, and review and approve county programs expenditures.

Activities

1. MHSOAC to convene PEI In-Service to educate California mental health community about best practices and priority areas in PEI. (1st quarter, FY 06-07)
2. MHSOAC to establish principles, criterion, and priority areas for PEI. (2nd quarter, FY 06-07)
3. MHSOAC to collaborate with DMH, CMHDA, CMHPC to establish Draft Requirements for PEI. (2nd quarter, FY 06-07). A critical part of establishing the Draft Requirements is seeking feedback from and the perspective of clients, multicultural communities, mental health providers and other mental health stakeholders.
4. MHSOAC to collaborate with DMH to ensure representatives of underserved and un-served communities are engaged in Stakeholder process to provide feedback on PEI Draft Requirements to DMH. (2nd quarter, FY 06-07)
5. MHSOAC to collaborate with DMH to shape strategy to establish stigma and discrimination approaches/programs at the State and County levels. (2nd quarter, FY 06-07)
6. MHSOAC to collaborate with DMH to initiate Stigma Work Group that will be responsible for planning stigma and discrimination reduction strategies. (3rd quarter, FY 06-07)
7. MHSOAC to approve final Plan requirements. (3rd quarter, FY 06-07)
8. MHSOAC will provide local plan review, comment and approval for each county's Three (3)-year PEI Plan. (1st quarter, FY 07-08)

■ **Innovative Programs (INN):**

The MHSOAC will ensure the implementation of Innovation Plans is consistent with the mandates of the MHSA, approve final Innovation Plan requirements, and review and approve county programs expenditures.

Activities

1. MHSOAC, in collaboration with DMH, to establish principles, criteria, and priority areas for INN. (3rd quarter, FY 06-07 through 1st quarter, FY 07-08)
2. MHSOAC to collaborate with oversight bodies and seek feedback from multicultural communities to assist in establishing INN Draft Requirements. MHSOAC to ensure inclusion of innovative principles and programs identified by multicultural communities in INN Draft Requirements (alternative treatment approaches; cultural specific approaches) (1st quarter, FY 07-08).
3. MHSOAC to work in collaboration with DMH to finalize INN Plan requirements (1st quarter, FY 07-08)
4. MHSOAC will provide local plan review, comment and approval for each county's Three (3)-year INN Plan (3rd quarter, FY07-08)

III. Establish Expectations for Statewide Outcomes Accountability¹ **(MHSOAC Roles 1, 2, 4, 7)**

Ensure that the State and Counties are accountable for positive outcomes for individuals with mental illness. Potential activities may include:

- Ensure that County and State programs funded by MHSA will participate in the development and use of a statewide evaluation framework that documents meaningful outcomes for individuals, families, and communities.
- Ensure County and State plans include well-conceived strategies to assess the effectiveness and outcomes of their programs, and reflect what is learned to all levels of the system in order to improve services and outcomes.

IV. Develop and Take Action on Statewide Policies that Promote Systems Transformation² **(MHSOAC Roles 1, 2, 3, 5, 7)**

The MHSOAC will initiate an organized a process to ask key policy questions, and to also establish an agenda and action plan to address specific policy issues. Potential policy areas include:

¹ Implementation of activities associated with this strategy is dependent on: (1) MHSA Plan Review responsibilities, and, (2) MHSOAC staff resources. This work is not likely to launch until 2008.

² Development and implementation of activities associated with this strategy is dependent on: (1) MHSA Plan Review responsibilities, and, (2) MHSOAC staff resources. This work is not likely to launch until 2008.

- ***Elimination of Disparities-*** To support strategies which move toward equal access and quality of care without racial/ethnic, gender, income, age, and geographic disparities.
- ***Leveraging Resources-*** To promote system transformation and increased capacity, explore (1) Medicaid waivers and other strategies to increase emphasis on service transformation while maintaining compliance with CMS; (2) Explore the alignment of mental health funding streams with the funding streams of other state departments' providing support, care, education, and/or treatment to Californians with mental illness, (3) Explore how to maximize funding related to mental health with private foundations.
- ***Wellness and Recovery-*** To establish training standards at the state, and local levels, and within provider organizations for Wellness and Recovery best-evidence models of practice.
- ***Assets and Resiliency- Creation of "Help First" System-*** To explore how new collaborations at the state and local level (resulting from MHSA implementation, litigation, new legislation) can create policies that better address the needs of Californians, particularly those from underserved communities, at risk for development of mental illness, *i.e.* children and youth in the foster care system, and children and youth at risk for entering the juvenile justice system.

Newly Proposed Calendar of Full Commission Meetings and Commission Committees and Technical Work Groups

Introduction

Since its establishment in July 2005, the MHSOAC has been meeting 10 times per year. The Commission meets monthly with the exception of the following months: August and December. In addition to meeting 10 times per year, the MHSOAC currently has 8 Committees that consist of 2 Commissioners that serve as Co-Chairs, other Commissioners, 15 public members, and representatives from the State Department of Mental Health and the California Mental Health Directors Association. The following is a proposal of structural changes for consideration by the MHSOAC to improve the Commission's operational efficiency and effectiveness in fulfilling oversight and accountability functions.

The current Work Plan proposes changes to the number of times the full Commission meets, and the number of standing Committees that are organized around the current oversight priorities of the MHSOAC. As defined earlier in this document, these priorities include:

1. Collaboration with DMH in development of draft requirements for MHSA components, both current and for MHSA Integrated Plan (FY 08-09);
2. Establishment of process for plan review and approval of expenditures in Prevention and Early Intervention & Innovation;
3. Implementation of plan review and approval in Prevention and Early Intervention & Innovation;
4. Establishment of stigma and discrimination reduction as an MHSA priority and design of an approach and funding strategy for stigma and discrimination reduction

Commission Meetings

Monthly meetings do not allow staff, to adequately prepare for the full Commission meetings. As a result, MHSOAC meetings at times lack the degree of content specificity and necessary action items and policy recommendations that would warrant the time and expense associated with each meeting. In addition, a great deal of Commission business occurs at the Committee level. It is difficult to have each Committee meet with the frequency necessary for them to prepare for monthly Commission meetings. Monthly meetings require unpaid Commissioners that already have full time positions to leave their jobs for the equivalent of two days (this include meeting and travel time). In order to allow Commission meetings to have meaningful content, Commissioners also spend a minimum of one day in Committee meetings (this includes meeting and travel time), and are involved in conference calls preparing for Committee meetings. This significant expectation of time dedicated by Commissioners to the MHSOAC can potentially lead to their "burn out" and, as a result, their inability to stay on the Commission.

In order to address the issues identified above, this Work Plan is proposing that beginning in January 2007, 6 full Commission meetings will be scheduled per year. Meetings will occur every other month, on the 4th Thursday and Friday of the month. Schedule for meetings remaining in FY 2006/2007 meetings & FY 2007/2008:

1. November, 2006
2. January, 2007
3. March, 2007
4. May, 2007
5. July, 2007
6. September, 2007
7. November, 2007
8. January, 2008
9. March, 2008
10. May, 2008
11. July, 2008
12. September, 2008
13. November, 2008

The content focus for the 2007 meetings will be shaped by a number of factors, including comment and decision making around DMH Draft Plan requirements within all components of MHSA, review and approval of County Plans, policy issues identified within Committees where action is required by the Commission, ongoing reporting and Commission action on the MHSA fund issues (prudent reserve; expansion planning; fund levels, etc.), and topics identified by the Commission as requiring public hearings to ensure MHSA transparency.

Currently, DMH has requested that the OAC provide them comment, feedback, and opportunity for public testimony on MHSA components where requirements are currently being designed (Please See Attachment A). The proposed Standing Committees will need to address these requests from DMH.

Standing Commission Committees

During FY 2006/2007 and 2007/2008, Committees are organized primarily around MHSOAC Strategy II - *Provide Oversight over the Mental Health Services Fund and Ensure Accountability to the Intent and Purpose of the Mental Health Services Act (Strategy II refers to the work of the Commission on Draft and Final Plan Requirements as well as reviewing and approving of plans as directed by the Act)*.

Other MHSOAC Committees will be established only when the Commission has staff in place to adequately support and coordinate the activities of the Committee Thus, Strategy III, *Ensuring Statewide Outcomes* and Strategy IV, *Developing a Policy Agenda*, are also critical. However, due to the urgency of MHSA Plan development,

implementation, and review, Commission Committees to address these two strategies will be postponed until the staff infrastructure of the Commission is more developed and statutory requirements for MHSA oversight are met by the Commission. Strategy I, *Ensuring Transparency of the MHSA* will be primarily a staff function. Products and activities related to Strategy I will be reviewed and approved by the full Commission.

Each Committee will be comprised of a Chair, a Vice Chair and other Commissioners. Committee membership consists of MHSOAC Commissioners. At the beginning of each fiscal year or at the time the Committee is established, each Committee will work with staff to develop an annual Work Plan. Work Plans include goals, primary objectives, activities to achieve those objectives, and a timeline. Work Plans will also include a stakeholder and public participation plan.

The MHSOAC staff will provide Committees with support around coordination, policy development, and facilitation. In addition, they will work independently on projects and reports requested by the Committee Chair.

MHSOAC Committees have two specific roles. They serve as *advisory* to the full MHSOAC. In addition, they *oversee the implementation of MHSOAC strategies and activities*. Committee annual work plans will identify key policy issues or recommendations that will be brought back to the full Commission for deliberation.

There are four proposed standing MHSOAC Committees. (Please See Attachment C) for the 18-month period of January 1, 2007 – June 30, 2008. These are listed below:

1. **Executive Committee**
2. **Combined Prevention / Early Intervention and Innovation Committee**
3. **Community Services and Supports Committee (with an additional focus on Capitol and IT)**
4. **Education and Training Committee**

The broad charge of each Committee is defined below:

1. Executive Committee

Provides the MHSOAC with leadership and establishes the strategic direction of the MHSOAC. Responsible for overseeing all activities related communicating to public the impacts of mental health service transformation. Ensure key issues (legislation that impacts MHSA, organizational issues, MHSA implementation issues) that arise between Commission meetings and require immediate action are deliberated and an action strategy is adopted. Decisions are ratified by full Commission at the next MHSOAC meeting. In the event that a final decision must be made prior to a full Commission meeting, the Executive Committee is authorized to do so.

2. **Prevention /Early Intervention and Innovation Committee**

This Committee has three primary tasks:

a. Prevention and Early Intervention: Establish and implement a plan for Prevention and Early Intervention Plan Review and Approval. Establish review and approval criteria and requirements.

b. Innovation: Establish plan for development of vision, principles, and priority areas for Innovation Plans. Establish and implement plan for Innovation Plan Review and Approval. Establish review and approval criteria and requirements.

c. Stigma and Discrimination Reduction: Through the use of an advisory Task Force of key stakeholders, establish the plan for the development of vision and approaches to MHSA funded stigma and discrimination reduction, including recommendations on MHSOAC involvement in stigma and discrimination reduction strategies. The Committee should propose funding principles for Statewide and County stigma and discrimination reduction approaches.

3. **Community Services and Supports**

Establish plan for review and comment on CSS Plan Updates and Capitol and IT Plans. Identify policy issues resulting from CSS Plan review and establish objectives and activities within Work Plan to address those policy issues.

4. **Education and Training Committee**

Establish plan to provide oversight over the Education and Training component of the MHSA, including implementation and expenditures. Articulate a vision for California's mental health workforce and present recommendations to DMH, CMHPC, CMHDA, diverse stakeholders, the public, the governor and the legislature regarding mental health workforce transformation.

Standing Commission Technical Resource Groups

The Commission will have two Standing Technical Resource Groups as follows. The broad charge of each Standing Technical Resource Group is defined below:

1. **Client and Family Technical Resource Group**

Ensure that the perspective and participation of those living with mental illness and their families members are a significant factor in all Commission decisions and recommendations. This Committee will have a specific focus on individuals living with mental illness and members of traditionally underserved communities

2. **Cultural and Linguistic Competence Technical Resource Group**

Ensure that the Commission has an ongoing focus in the area of access, quality, and outcomes disparities in mental health service provision to underserved communities.

3. **Outcomes Technical Work Group**

Ensure that the Commission, in collaboration with California Mental Health Planning Council and Dept. of Mental Health, has an ongoing focus on statewide outcomes.

Action Items

Decision Point # 1 Requiring Action by the Commission: Stakeholder and Public's Participation in the Work of Commission Committees

Below are the three options for public/stakeholder involvement in the MHSOAC which were discussed at the October Commission meeting. The first option is what was proposed in the Draft Work Plan # 3. The second and third options are descriptions of other models of public/stakeholder involvement in the MHSOAC that were introduced on October 26th. Commissioners will take action and adopt a model for public participation on the MHSOAC in November Commission Meeting.

Option A.

The Commission is dedicated to meaningful and inclusive public and mental health stakeholder participation in all of its work. The diversity of ideas brought forward through ongoing stakeholder and public involvement and inclusion will enrich and shape the Commission's discussions and decisions. The statute reinforces this commitment and highlights that the perspective and participation of consumers, family members, and underserved communities, need to be a significant factor in all of the Commission's decision and recommendations.

Much of the work of the Commission is conducted through Commission Committees. An option to be considered by Commissioners for Committee structure and inclusion of the public is: Commission Committees are comprised of Commissioners. Each Committee is then charged with developing a stakeholder and public participation plan that provides meaningful opportunities for inclusion in the Committee's work.

Attached is a list of sample options for public and stakeholder participation for Committees to use as a point of reference. (Please See Attachment B) Different options are useful for different situations, based on the needs of the Committee. The list is not meant to be exhaustive, but it does describe the tools that are most typically used. It is important to note that any one option can be used in combination with other options to provide further opportunity for participation and inclusion.

Option B.

The Commission is dedicated to meaningful and inclusive public and mental health stakeholder participation in all of its work. The diversity of ideas brought forward through ongoing stakeholder and public involvement and inclusion will enrich and shape the Commission's discussions and decisions. The statute reinforces this commitment and highlights that the perspective and participation of consumers, family members, and

underserved communities, need to be a significant factor in all of the Commission's decision and recommendations.

Much of the work of the Commission is conducted through Commission Committees. An option to be considered by Commissioners for Committee structure and inclusion of the public is: Committees are comprised of Commissioners and members of the public. Commissioners are appointed by the Chair and Co-Chair of the Commission to serve as the Chair and Vice Chair of the Standing OAC Committees. The Chair and Vice Chair work closely with their staff coordinator and assigned policy expert to establish a Work Plan at the time of being established or at the beginning of each fiscal year. The Work Plan includes Committee charge, goals, objectives, criteria for public membership, and the requested number of other Commissioners. Each Committee has no more than a total of 15 members (including Chair, Vice Chair, and other Commissioners). Upon completion and approval of Committee Work Plans by the full Commission, Chair works with staff to develop Committee application based on membership criteria established in the Work Plan. Once public members are chosen, they are members of the Committee serving at the invitation of Commissioner Chair and Vice Chair.

Committees are responsible for fulfilling the objectives of the Work Plan. All recommendations for Commission action that develop in the process of Committees completing their Work Plans are taken to the full Commission. No voting takes place at the Committee level. Only appointed Commissioners have the eligibility to vote on OAC Action Items and voting occurs only at full Commission meetings.

Option C.

The Commission is dedicated to meaningful and inclusive public and mental health stakeholder participation in all of its work. The diversity of ideas brought forward through ongoing stakeholder and public involvement and inclusion will enrich and shape the Commission's discussions and decisions. The statute reinforces this commitment and highlights that the perspective and participation of consumers, family members, and underserved communities, need to be a significant factor in all of the Commission's decision and recommendations.

An option to be considered by Commissioners for Committee structure and inclusion of the public is as follows: Standing Committees are comprised of Commissioners. Commissioner membership on Standing Committees, including the Committee's Chair and Vice Chair, are appointed by the Chair and Co-Chair of the Commission. The Standing Committee Chair and Vice Chair work with their staff coordinator and assigned policy expert to establish a Work Plan at the time of being established or at the beginning of each fiscal year. The Work Plan includes Committee charge, goals, objectives, and criteria for public membership. As part of the Work Plan, each Committee is charged with developing a stakeholder and public participation plan that provides meaningful opportunities for inclusion in the Committee's work. The Standing Committee's Work Plan will be ratified by the full Commission.

On policy topics of significance, the Chair and Vice Chair of the Standing Committee will identify public members to serve as an advisory body to the Standing Committee. The policy topics of significance will be identified in the Work Plan. The identified public members will serve as advisors for a designated period of time on a specific policy, for example the development of the PEI proposal that recently went before the Commission. Each of these Committee efforts will have no more than a total of 18 public members.

The Committee Chair works with staff to develop and distribute in a timely manner a Committee membership application for public members, based on criteria established in the Work Plan. For each policy topic that emerges, the Committee Chair and Vice Chair will identify the public membership for ratification by the Commission's Executive Committee.

For Committee efforts with public members, the Commissioner members will have the authority and responsibility for developing the proposal and accompanying recommendations for the full Commission's action. Where there is overall agreement among both the Commissioners and public members of the Committee, it will be highlighted in the Standing Committee's proposal. Where there is disagreement among the Commissioners or between the Commissioner(s) and members of the public, multiple options will be submitted to the full Commission with an explanation of the various viewpoints. The Standing Committee Commissioners have the prerogative of identifying in the proposal which option they support.

No voting takes place at the Committee level. Only appointed Commissioners have the eligibility to vote on OAC Action Items and voting occurs only at full Commission meetings.

Decision Point # 2 Requiring Action by the Commission: Technical Resource Groups/ Committees

During the October meeting, Committees and Technical Resource Groups were discussed and deliberated. Below are 4 options the Commission will take action on in the November 2006 Commission Meeting.

Option A. The Commission consists of 4 Committees (EXEC, CSS/CAP & IT; PEI/INN; ED & TR), 1 Task Force (Stigma and Discrimination Reduction), and 2 Technical Resource Groups (Client and Family; Cultural and Linguistic Competence).

Option B. The Commission consists of 4 Committees (EXEC, CSS/CAP & IT; PEI/INN; ED & TR), 1 Task Force (Stigma and Discrimination Reduction), and 2 Technical Resource Groups (Cultural and Linguistic Competence and Outcomes- introduced in October Commission discussion and responsible for ensuring statewide outcomes of MHSA).

Option C. The Commission consists of 4 Committees (identified above), and 3 Technical Resource Groups (Client and Family; Cultural and Linguistic Competence; and Outcomes).

Option D. The Commission consists of 7 Committees (Executive, Community Services And Supports/ Capitol And It, Education And Training, Client And Family, Cultural And Linguistic Competence, And Outcomes) and 1 Task Force (Stigma and Discrimination Reduction).

Conclusion

The primary responsibility of the Mental Health Services Oversight and Accountability Commission is to redirect California's mental health system toward transformation, such that all mental health activities and programs stress prevention, early intervention, wellness, recovery and resilience. The Commission is responsible for ensuring transparency of its own decisions and recommendations. It is also responsible for creating transparency in the overall implementation of the Act. The Commission is accountable to the public that enabled the MHSA fund to be created.

The current Work Plan, spanning FY 2006/2007 and FY 2007/2008 focuses the work of the Commission. It creates mechanisms to ensure that the perspective and participation of those living with mental illness, their family members, and members of underserved communities maintain a significant role in all of the Commission's decisions and recommendations. It promotes activities to eliminate disparities in access, quality, and outcomes of mental health services. Finally, it ensures that the general public and stakeholders have a mechanism to be informed about the impact of the MHSA monies on the mental health of all Californians.