

COMMISSION MEETING MINUTES
Thursday, March 22, 2007

I. Call to Order

Vice-Chair Gayle called the meeting to order and welcomed everyone.

II. Roll Call

Present were Commissioners Wesley Chesbro, Carmen Diaz, Paul Dobson, Jerome Doyle, Saul Feldman, Linford Gayle, Patrick Henning, Jr., Karen Henry, Gary Jaeger, William Kolender, Kelvin Lee, Andrew Poat, Darlene Prettyman

Absent at roll call were: Commissioner Mary Hayashi

III. Purpose of Meeting

Vice-Chair Gayle said there has been changes in the agenda and the changes are: (1) extend the time for the community and training resource group's reports; and (2) integrate the Mental Health Services Act Native American services into the CSS report.

MOTION: Commissioner Poat moved approval of the agenda changes, seconded by Commissioner Lee. Motion carried unanimously.

Vice-Chair Gayle said the following topics will be discussed at today's meeting:

- The Mental Health Services Act Information Technology Program Component: Program Requirements and Budget
- The Mental Health Services Act Capital Program Component: Requirements and Budget & Housing Initiative: Final Application
- Updated Mental Health Services Act Timeline, Revenue and Expenditures
- Mental Health Services Act Updated Emergency Regulations:
 1. Process for Adoption and Timeline
 2. Recommendations for Involuntary Treatment
- Mental Health Services Oversight & Accountability Commission Maintenance of Effort Work Group: Recommendations for Mental Health Services Act Maintenance of Effort, County & State

IV. Digital Health Records

Commissioner Poat said a presentation will be given on Digital Health Records. He provided the following background information:

- Federal and State laws mandate electronic health records (digital health records) by the year 2014.
- Digital records could be an important key to service transformation, both in terms of the effectiveness and the efficiency of health care

- The counties and Department of Mental Health Services have been working, prior to the passage of MHSA, to come up with an approach by which to implement this strategy.
- MHSAOC Committee on Capital Facilities and Information Technology began meeting last summer. Members of the Committee consisted of himself, Commissioners Diaz and Henning and a variety of public volunteers.
- The Mental Health Services Act provides for Capital Facilities and IT to receive 10 percent of funds for the first 3 years (now extended to 4 years)
 - The available funds are between \$150 and \$200 million over 4 years. Anticipated revenues are somewhere over \$200 million.
 - 14 counties have already received some IT funding and 10 counties are currently in review.
 - These funds cannot pay for the entire transformation but can provide some part of planning and moving in this direction.

Timeline

- One time funding proposals for four years, the standards are expected by October 2006, RFI by winter 2007
- Implementation 2014
- Electronic signature – expect policy document from the State of California within the next 2-3 months
- Personal Health Record (PHR) survey to be distributed by March 15th through consumer advocacy groups to monitor their reaction to some proposals.

Policy Questions Identified by OAC Subcommittee

- Consensus on use of MHSA funds
 - Obviously, there must be some sort of link to the MHSA goals
 - What investments are NOT going to be made in order to make these investments in Information Technology?
 - Transparency of all processes in which MHSA funds are involved
 - Oversight: Ensuring efficiency and effectiveness
- Operational Issues
 - System security
 - Interoperability
 - Open-network architecture
 - Patient access

DMH Presentation Request

DMH has been asked to explain today:

- The role of digital records in improving service delivery quality and efficiency
- Framework for their initiative
- Key Partners
- Key issues settled
- Key issues outstanding

Following the DMH Presentation

- The Oversight and Accountability Commission will discuss what role it should play regarding digital health records. Some questions the Commission will be addressing is (1) what is the road map and timeline from here; (2) what is the procedural of MHSA dollars at achieving a digital record system; (3) what other sources are going to be used; and (4) how will the process of developing recommendations and programs benefit from public input.

Questions from Commissioners:

Commissioner Chesbro asked where the decision to use MHSA funds will be made. Commissioner Poat said he is looking for this same answer and it is hoped the presentation by DMH will answer this, as well as other questions.

Commissioner Chesbro also asked if this is something that would have been required regardless of the Mental Health Services Act, and therefore is there potential for supplantation. Commissioner Poat said the key question is whether the Commission could accomplish the MHSA goals without this transformation.

Vice-Chair Gayle welcomed Rebecca Skarr, Chief of Applications Development California Department of Mental Health to the meeting.

Ms. Skarr introduced Lori Hack, Project Manager, EHR/HIE/PHR (who is an industry expert on electronic health records), and Corina Leon, Requirements Coordinator, EHR/HIE/PHR who works full time as support on the Mental Health Services Act.

Ms. Skarr provided the following presentation:

- The Mental Health Services Act Technology Goal is to transform the county/local mental health technology systems into an accessible, interoperable, comprehensive information network that can easily and securely capture, exchange, and utilize information to facilitate the highest quality, cost-effective services and supports for consumer and family wellness, recovery and resiliency.
- Industry was definitely moving towards electronic health records and she believes if it was not for the MHSA funding this could not happen.

A Commissioner said it was stated that “without the MHSA funds electronic health records would not be met”, but the Federal and State laws mandate these records so why wouldn’t the state legally be required to have these records in place at the State. Ms. Skarr said it would be put in place as a “bare minimum” requirement. Processes would be put in place that are inefficient and would only meet the minimum requirements. She is looking at doing far more than this. She is looking at putting this in place in a manner that facilitates care and treatment of consumers which will improve their lives, as well as improves the clinician’s ability to provide these services.

- In FY 04/05 forty five percent of the funding was allocated to Capital Facilities & Technology. In FY 05-06 to 08-09, ten percent is available. In FY 09-10 and beyond 20 percent of the 75 percent would be available as a prudent preserve for multiple efforts.
- Total estimated amount for Capital Facilities and Technological funding for the FY 04/05, 05/06, 06/07, 07/08, and 09/09 is \$597 million.
- 15 counties have requested some technology funds and another 10 are still waiting to be approved.
- The MHSA specifies a one-time and ongoing funding for technology needs.
- This funding facilitates health technology transformation by supporting:
 - Public access to computers, internet, computer literacy
 - Infrastructure (computers, telecommunications, etc.)
 - Mental Health Electronic Health Record (HER) and Personal Health Record (PHR) Systems
 - Health Information Exchange (HIE)
 - Tele-medicine/Distance Learning
- Critical information will be available for consumers and family members in planning for their wellness, recovery and resiliency.

- This allows for consumer interface with their own HER or PHR with access to lab results, prescription information, etc.
- Can bridge gaps in service brought about by geographic isolation (telemedicine)
- Improves quality of care to the consumer by making information available to the clinician for improved coordination of care
 - This allows for the reduction in the ordering of duplicate tests and/or medications
 - Delivers drug-interaction warnings and guidelines to providers based on individualized consumer information
 - Increases access to consumer and clinical information necessary to support treatment
- The MHS Technology Workgroup is currently comprised of representatives (75 to date) from the following:
 - Mental health services consumers and family members
 - Organizations representing consumers, family members and parents
 - Mental health services providers
 - California counties (small, medium and large)
 - Currently contracted county IT vendors
 - This workgroup started in October 25, 2005 and it has held 19 meetings and conference calls to date
 - The workgroup has participated in the MHS stakeholder input process
- MHS Technology Funding Plan Timeline
 - Technology Plan Requirements should be completed by June 2007.
 - The first draft for stakeholder input will be available April 2007
 - DMH will update the draft with comments from CMHDA and each sub-group in Technology by May 2007
 - DMH will review draft and make the final plan requirements available in June 2007.
 - The earliest a county could submit a plan for technology funds is September 1, 2007 with the first funds being approved by October 31, 2007.
- California counties will submit Technology Funding Plans in response to the DMH requirements
- DMH and OAC will review the plans
- DMH will work with each county for any required clarifications/modifications
- Upon approval of each plan, DMH will continue to work with each county to help ensure the success of the MHS projects and provide shared learning to the counties
- One of the components of public access is to work with stakeholders to define the best approach:
 - Computers accessible 24 hours a day
 - Computer locations at wellness centers, county computer labs, housing facilities, etc.
 - Secure internet and broadband access
 - Computer literacy training
 - Readily available technical support
- Additional requirements include Electronic Health Records (HER), Health Information Exchange (HIE) and Personal Health Record (PHR) Standards
 - Some national standards have been developed that vendors are following and there needs to be alignment with those standards. Determine the initial minimum standards for content, security, functionality and interoperability:
 - California Behavioral Systems Coalition documentation
 - Leveraging national standards:
 - HL7 EHR Functional Model
 - CCHIT (Certification Commission of Health Information Technology) certification criteria for EHRs
 - HISPC (Health Information Security and Privacy Committee)
 - Engaging industry experts for EHR/HIE/PHR system evaluation criteria
 - Reviewing data content necessary for accountability, performance measurement, quality of care demonstration, state oversight and continuity of care

- Provide baseline requirements for EHR and HIE RFI
- The Department of Health will be releasing two RFI's in the near future to assist the county so they will not have to do repetitive work. One RFI will be for Electronic Health Records and one for Health Information Exchange.

Commissioner Lee asked what help this system could be to law enforcement when they pick up a consumer for problems because right now the largest provider for these types of consumers is jail. Ms. Skarr said it would be up to the consumer as to whether they want information made available. There is an issue with privacy as far as what information consumers want made available to groups and this would have to be made on a case-by-case basis.

Vice-Chair Gayle said when a consumer is homeless and goes into the jail system the jail providers treating the SMI clients have connection to their public health records. There is no need for police officers to have the data, but the providers within the jail system should have the data.

Ms. Skarr continued with her presentation as follows:

- The EHR System Timeline
 - EHR RFI results: September 2007
 - Stakeholder process to develop RFI: June 2007
 - Vendor Demonstrations: July 2007
 - Vendor information submissions: July 2007
 - Develop Vendor Evaluation Sheet: September 2007
 - Develop EHR/HIE Technical Standards Document to be updated bi-annually: October 31, 2007

The question was asked if there is a list of preferred vendors that the State has available. Ms. Skarr said this will be produced from the above process. A side-by-side comparison will be available. The mental health providers that have specialty systems that include components for mental health will be engaged in this process.

Ms. Hood, from the State Department of Mental Health, said the Department is not looking at limiting choice to the list of vendors that have been validated, but if the county comes in with a vendor that has not been through the validation process, there would be a more rigorous evaluation of their proposal.

Commissioner Poat said that the purpose of today's meeting is not to focus on the applied decisions, but the big picture. The big picture is: Where is this going and what is the role of MHSA funds in this particular initiative? Subsequently, the Commission can look at specifics within components of the program if it chooses to do so.

Ms. Skarr continued her presentation as follows:

- Develop HIE Implementation Plan by July 2008
- Other considerations moving forward are:
 - Develop a working committee for oversight of funding and use of the HIE statewide
 - Assess the potential behavioral health specialty certification via the Certification Commission for Healthcare Information Technology (CCHIT). They are earmarking behavioral health as the next specialty they will look at in the second half of this year.
 - Exploring funding sources other than MHSA for EHR/HIE/PHR adoption
 - Collaborating with the Department of Health Services, the Office of the State CIO, and Department of Technology Services on statewide health technology strategies

Questions from Commissioners:

Commissioner Chesbro said the privacy of all medical records is of paramount importance. It is important that information is not being used inappropriately and in order to facilitate this, consumer involvement is critical. He also believes that the consumers should be in the forefront of the decision making regarding access to technology. Ms. Skarr said consumers are being engaged and they are helping the Department come up with the requirements, such as ensuring that there is availability in multiple types of locations, etc. Ms. Skarr will get a copy of the list of members who are on the MHSA Technology work group to the Commission.

It was mentioned that organized labor often times gets mixed in with different groups and are not singled out, but they should be.

Commissioner Diaz asked if minors' records are closed after a certain amount of time. Ms. Skarr said this information will never be available to an employer.

Commissioner Diaz asked if family members or consumers will be able to add to their own records. Ms. Skarr said the vision is to have this exchange, however it might not be in this generation. Information will be available for clinicians to review and update information if they are willing to do this. Commissioner Diaz said she fears that families or caregivers will have to re-start their care because there may be a provider who has read the information, but who will still want to start fresh.

Commissioner Poat said many issues will exist, whether you have digital records or not, and this is not the forum to address subcomponent problems. At some point it may become a vehicle to examine and re-visit how information will be dealt with, but at this point we are trying to focus on the big picture of trying to move towards Electronic Health Records.

Commissioner Chesbro asked where the decision is made to allocate MHSA funds for this purpose. Commissioner Poat said these projects were part of the CSS plans and they have come through the Commission.

Commissioner Chesbro asked whether the Department makes a distinction between what the Commission would be required to do under Federal law and what it is trying to do to enhance that, and whether there are several funding sources based on this or whether all of this is being paid for out of the Mental Health Services Act. Ms. Skarr said other funding sources are being looked at but the primary source of funding is the MHSA and any other county national or local funds.

Commissioner Chesbro asked what is being done to make sure that systems can talk to each effectively. Ms. Skarr said this is what interoperability is about. Trying to define what interoperability is and how there can be messaging from one system to another. National Organizations will be assisting in this effort.

It was stated that if this technology is a mandate of the federal government upon the state, then how much of the funds will come from the state and how much of the funds will come from MHSA. Commissioner Poat said the MHSA does not have enough money to pay for everything and it is not being proposed that MHSA alone pay for this initiative.

Commissioner Lee said in the year 2014, when the requirements are placed upon the state to conform to the Federal mandates, is there something that will be used as a standard to indicate that the federal requirement has been met. Do we know what we are supposed to do by the year 2014? Ms. Skarr said the state has not been given individual requirements but she can report back on both federal and other state law requirements.

Vice-Chair Gayle suggested that the Commission discuss these concerns after public comment.

Commissioner Lee said it would be helpful to see a clear statement of purpose - what are the major things that is hoped to be accomplished with this electronic system and what will it produce. Also, the issue of confidentiality is important and when he sees the term "integrated medical records" he is concerned.

Commissioner Jaeger said the State of California would have to comply with the federal requirements even if there were no MHSA money and he does not want to see MHSA funds used for the compliance of these federal regulations.

Public Comment

Belinda Lyons, Executive Director of the Mental Health Association of San Francisco, said that her organization took part in the Prop 63 Steering Committee at the state level and led the local campaign in San Francisco. She believes that San Francisco is well placed to be a model of innovation and excellent outcomes for Prop 63.

The Department of Mental Health's allocation formula, including a prevalence formula that was greatly flawed and seriously underestimated the need and prevalence of mental illness in San Francisco, led to a very low allocation for San Francisco. San Francisco received the lowest allocation per capita in the State of California. It was not taken into account the high homeless population, the day time population that commutes to San Francisco, and people who move to San Francisco because of the excellent services. There is a need for 1,300 additional FSP slots for clients in San Francisco.

She asked the Commission to consider the following: (1) for the next three allocation processes, change the allocation formula to use a correct estimate of prevalence; (2) adjust the current allocation for the upcoming programs such as the prevention early intervention; and (3) immediately make an annual increase to provide services to an additional 1,300 FSP client slots in San Francisco.

Alecia Hopper, with Mental Health Association of San Francisco, said San Francisco is a unique community with a variety of mental health needs. Housing is particularly crucial in San Francisco based on the high cost of living and the limited amount of affordable housing which creates homelessness. She thanked the Commission for making housing a priority.

She is excited about the prevention and early intervention dollars because this will help transform the local mental health systems and serve as a model for other states across the country. The Mental Health Association's Health and Wellness Advocates will help keep consumers connected to community in advocating for change in the community. Another program she would like the Commission to consider for prevention and early intervention dollars is the Tenant Leadership Training, which is leadership training for consumers who are tenants living in supportive housing. The goal is to improve the quality of supportive housing. She is looking at creating a new program called the Program Provider Sensitivity Training which will work with consumers to train clinicians on reducing stigma.

Sylvia Caras said she represents the California Network of Mental Health Clients and the International Disability Alliance in matters connected to Information and Communication Technology. She is also part of the United Nations Internet Governance Forum. She said access issues for most left out groups are similar; insufficient resources for participation on an equal basis for people who cope with mood swings, fear, and voices and visions. Electronic accessibility means inclusion in, and access to, information and communication tools just like

everyone else. Access creates opportunities to everyone in society, but perhaps no more so, than for persons with disabilities. No longer do the societal barriers of prejudice, infrastructure and inaccessible format have to stand in the way of participation.

It is fortunate that there is new funding dedicated to these new technologies. We can further the spread of justice and social equality through the universalization of access to knowledge. The network has detailed recommendations that they will send forward to the Commission. Her personal goal is that all clients should be computer literate and have access to hardware, connectivity, information, and each other.

Commissioner Chesbro asked if the Network has been involved in protecting the privacy of clients. Ms. Caras said the Network has discussed this issue. The privacy issue is important for everybody and there are a lot of technical things that can be done regarding specific access to specific parts of records, etc. She said the IT part of the Department of Health has been superb in including the Network on this issue. Copies of information were disseminated to the Commissioners.

Joan Hirose said she is a licensed member of the healing arts. She is employed by the Department of Education in the Special Education Division. The mission of the Department of Education is to provide leadership, oversight, assistance and resources so that California can receive a world class education. The mission is to provide excellent education so students can excel, not only in education, but as parents and citizens.

Her areas of interest are disproportionality; the high percentage of over represented students of certain racial and ethnic populations in the special education classes. There are many non-English speaking students. She is also concerned about female students who are self-medicating in co-occurring disorders. She has been working with members of NAMI and UCAF on health centered mental health education. She asked that everyone get together at the local level to work on the County Mental Health Services Act plan.

Deborah Taylor said it has been her experience, with her own disability, that when she tries to access service she, at times may get excited and become loud and the reaction of the service provider is that she is threatening as opposed to trying to understand her. She believes service providers need more training in dealing with people with disabilities. She asked the Commission to address her concern of the CSS allocation formula and to allow more funds to mental health services and training for staff working in supportive housing.

C. W. Johnson said he had been homeless for about 75 percent of the time that he has been in San Francisco, which has been for the last 25 years. He is a tenant mental health advocate who associates with the Mental Health Association and he is co-facilitator of the Tenant Leadership Training.

He said the allocation formula needs to include both housed and homeless consumers for surviving mental illness. He said using MHSA funds to hospitalize people involuntarily is against the spirit of prevention. Due to the cost of living and lack of housing in San Francisco, many consumers are forced to live in shelters that are sometimes more dangerous than the streets. Consumers are moving into SROs with no option of advancement to studios, one bedroom or even to rent a house. He said there is a place called the Progress Foundation that has a good formula. Consumers go from the hospital to board and care, and then to co-ops, then into studios and one bedroom.

Marilyn Schrick said she is an advocate for seniors with the MHSA. In 1990 she became destitute and had no place to live. She was a member of AA and relied on fellow AA members to

provide her housing and food. Later, she found that even in AA when she was suicidal and desperate, it did not work. Nothing worked.

Progress Foundation helped her in her adjustment from the medical institution into an SRO. Several years ago she began having mental and financial problems and did not know where to turn. Welfare provided her training and she was able to find work. She was homeless and went to shelters for food and lodging.

San Francisco is a dumping ground for many people who are not wanted in other areas and it has good resources for the mentally ill. She asked that the formula be changed to correct the deficiencies.

Dorothy Friberg said she is a consumer, survivor, ex-mental patient and she is homeless because she owns a lot which she cannot afford to build on so she lives in a Van. She is on the Consumer Advisory Committee for the MHSA distribution of money in Sonoma County. She sees the emergency regulation as a raid on MHSA funds to 51/50 people for 30 days. In her county, MHSA funds are only 15 percent of their mental health budget. The mentally ill are not helped by money, they are helped by relationships.

Jeffrey Giompetro, a consumer from San Joaquin Valley, said he will be talking about access and privacy. He said he noticed in the draft, that the word cross platform is not included, and for consumers it is important that these words be included. There needs to be a system where the consumer can access it wherever they go. Regarding privacy, there was no word of encryption included in the draft. This should be included. There is also a need for people to have their own computer to be able to access the information because it is hard to have privacy when you are in a public setting accessing a computer.

Chair Steinberg arrived and chaired the remainder of the meeting.

Commissioner Poat thanked Ms. Skarr for her presentation. He said the purpose of this presentation was to get this information out in the open and to expose the Commissioners to the fact that these decisions are being made. The MHSA funds that will be dedicated to these projects will be spent through the CSS or Capital and IT plans. He said that he will review and discuss the key issues that were heard today with staff and report back at the next meeting. His observations at today's meeting are:

- The road forward will occur through the CSS county plans and the Capital and IT plans.
- The goal of getting a clear statement of objectives is needed.
- There was a notion that MHSA should support those activities above and beyond the Federal standards because the Federal standards should be met with other funds.
- There has been much interest on the role of consumer, family and employee input. He will look at the list to be sure that all the groups that have been discussed at today's meeting have had a chance to participate in the process.
- How will the relationships be arranged with counties so there is assurance that there is some level of expertise, but that they have some reasonable flexibility.

The only motion that he would like to see today is a sense of capturing the Commission's consensus on what additional information it would like to have available.

Chair Steinberg said one of the key issues is how much, if any, the MHSA should pay for an otherwise Federal system that is required, regardless of the MHSA, which would bring up discussion of supplantation.

Commission Discussion

Commissioner Dobson said he would like to know what the Department's rationale is regarding MHSA funds meeting the requirement for mental health services expenditures and that it does not supplant other programs or violate the maintenance of effort requirement.

Commissioner Diaz said she would like to know how many people will use the IT, especially with regards to children, without having to start over from the same place. She said if it won't be used appropriately by the providers than why should MHSA funding be spent for capital facilities and IT. In other words, will service providers accept a common record system.

Commissioner Chesbro said that the Commission, consumers and families all need to know the basis for spending the money. He said he does have concern as to when is it spending that the State would have been doing, and is required to do anyway, and when is it an improvement and enhancement to the system that the voters intended when they approved Prop 63. He would like a response on this for ongoing monitoring of how the State Department, the Administration, and Legislature respond to the spending of MHSA money.

It was noted, that in terms of the kinds of information collected, it is important to make certain that there is enough commonality in the information to enable the Commission to fulfill its oversight and accountability responsibilities with the evaluation process. The information to be collected must be defined.

Commissioner Prettyman said she is concerned how the family and consumers will learn how to access the information and she believes that there needs to be education that goes along with this technology.

Commissioner Lee said cultural and linguistic sensitivity should be addressed and in the approval of this process there should be some defined outcomes and measures.

Chair Steinberg said this topic will be agendaized for the May meeting with follow-up from the Department and other entities as specified.

V. Minutes Approval

Chair Steinberg said that minutes of January will be approved at the May meeting.

VI. Capital Program Components: Program Requirements and Budget and Final Program Application for the Housing Initiative

Chair Steinberg introduced Ms. Jane Laciste, Chief of Special Projects for the Department, and Ms. Terri Parker, Executive Director of California Housing Finance Agency.

Ms. Laciste provided the following presentation:

The six components of MHSA are:

- Community Program Planning
- Prevention and Early Intervention
- Community Service and Support
- Capital Facilities & Technological Needs
- Education and Training
- Innovation

The Act designates specific percentages over different fiscal years which create a total of \$597 million. There is ongoing ability to use the funds under CSS up to 20 percent for capital facilities, prudent reserve, technology and education and training.

Commissioner Henning asked what the State intends to keep for itself out of IT funding and what the State intends to give to the counties to spend. Ms. Laciste said the Department is not doing any statewide programs for Capital Facilities & Technology. When she speaks about facilities under Capital Facilities she is talking about facilities and buildings that would be used to provide services and treatment and/or county administrative services and not housing.

Ms. Laciste continued with her presentation as follows:

The goal is to (1) increase the number and variety of community-based facilities which support integrated service experiences for clients and family members; and (2) produce long-term impacts with lasting benefits for clients.

The proposed capital facilities definition is:

- “Capital Facilities” means the portion of the Capital Facilities and Technological Needs component of the County’s three-year program and expenditure plan under which the county can acquire and/or develop land and/or construct or renovate buildings to support the mental health programs and services to be provided by the county through the CSS and PEI components of its three-year plan.
- It will fund acquisition, improvement and development of land; construction or renovation of a building or facility; and operating capital reserves
- Examples of how Capital Facility funds can be used are (1) Wellness and Recover Centers; (2) One-Stop Service Centers; (3) Clinics including co-located services; and (4) administrative offices. When a space is being shared MHSA dollars would only be used to pay for that portion of the facility that is designated for the mental health programs and services.
- Timeline:
 - Draft guidelines for stakeholder input – April, 2007
 - Finalize county plan guidelines – June, 2007
 - County plan development begins – June, 2007
 - Approve county plans, file emergency regulations – October, 2007

There will be a community planning process to identify needs and priorities in the counties. Decisions will be made at the local level with stakeholder input.

Chair Steinberg asked what the State’s vision is in terms of what is desired to be accomplished in the way in which the money will be spent. Ms. Hood said the State is looking at this as being a locally driven process because each county will have different needs and priorities. Chair Steinberg asked if more specific regulations will be developed to guide the county process. Ms. Hood said there will be regulations with less specificity and less rules around the capital.

Chair Steinberg asked if Capital Facilities is intended to be integrated in the first round with the other components of the Act. Ms. Hood said this absolutely needs to move toward the vision of the Mental Health Services Act and be consistent with what the counties are doing in their CSS and PEI. It can be for broader transformational issues but it must be consistent with each county’s local plans. The counties are guided through requirements, training, oversight, and technical assistance.

Commissioner Lee asked if there will be a common review practice to look at the county’s plan for construction; a process through which there is certainty that the kind of integration that is desired will take place. Ms. Hood said there was a decision to move forward incrementally in the

initial implementation. She understands the need for integration to make sure all the pieces come together, but if you wait until all of the rules are out there will be a delay in getting the money out. The State is trying to integrate, as quickly as possible, each of the components. The review process will be similar to the CSS process, where the Commission would be a reviewer of these plans. The Department would then get a review team of clients, family members, cultural competence experts, etc. to make sure there is a thorough review.

Ms. Hood said the State believes that you cannot move forward on the technology without also doing Capital because the money goes together. It would not be possible for locals to make the priorities unless they knew what their choices were. Therefore, if there is a delay on the Capital it would also affect technology and counties are in desperate need for moving forward on technology.

Chair Steinberg said the Commission would like to see the money get out quickly, but they would also like vision embodied within the State guidelines. If nothing more than to say that the Department is going to evaluate the county applications based, in part, on whether or not the money requested is consistent with the monies requested from the other sources of money; that there is some integration to make sure that the pieces all fit together. Ms. Hood said she believes the Commission will see this when the actual draft requirements are out.

Final Program Application for Housing Initiative

Jonathan Hunter, Consultant with the Corporation of Supportive Housing updated the Commission on the Housing Initiative. The Housing Initiative is designed to specifically create permanent housing and not intended to address all the housing needs that all consumers may have related to the Mental Health Services Act.

The MHSA Housing Program target population, as proposed, does not include children with serious emotional disturbances and their parents/caregivers. The following two issues guided this policy:

- Including households in which a child is the only disabled member creates significant fair housing issues because when the child becomes independent the family cannot be evicted from the home and MHSA funds would be used to provide housing for non-MHSA eligible tenants.
- There is a serious problem with trying leveraging other resources because capital investment with other sources because they don't define a family's disability based on the disability of the child rather than one of the adults in one of the family.

There are serious housing issues faced by families with children with special needs. He is working with advocates and participants, such as United Advocates for Children of California, the California Alliance of Child and Family Services, Department of Mental Health individuals who work with families of children with special needs, developers, and people in the homeless advocacy arena to try to more clearly define what the problems are and how they can be addressed with MHSA resources.

The issues have been defined into two key categories: (1) families are being evicted primarily because of the behavior issues of the children or because the behavior and health needs of the children create an interruption in the family income. (2) homelessness – most homeless services tend to prioritize family with children but are structured in such a way that it makes it impossible for them to respond to families with children, i.e., if the family has male children over a certain age they cannot get in to most shelters and family service programs. Families are literally faced with having to surrender custody of their children in order for either themselves or their children to get shelter and transitional housing.

The following options for meeting the housing needs of children with SED and their parents/caregivers are:

- “Rent Plus” Programs Used by a number of AB2034 programs, “rent plus” interventions are a promising alternative for addressing housing issues of children and their parents/caregivers. This was a strategy developed by many of the AB2034 contractors who were able to successfully use direct rent subsidies and/or other kinds of agreements to cover unusual costs of landlords and property manager to build an alliance with them to get people off the streets and into permanent housing. This strategy could be used for any children enrolled in Full Service Partnerships. The strategy involves developing working agreements with landlords/property managers to guarantee rent payments (an eligible expense with FSP funds), and/or to guarantee coverage of unusual damages. One of the most popular elements of the strategy for landlords is to give them 24/7 access to crisis intervention services. For children not in Full Service Partnerships, such access to crisis intervention may be enough to gain landlord cooperation even apart from ability to subsidize rent. Counties may want to consider this strategy as a program under CSS.

The State is going to put together an ongoing work group to work with families, advocates and stakeholders to continue to articulate the barriers and issues that families are facing, and then develop practical strategies and tools to address the needs with existing resources.

Chair Steinberg asked why the families couldn’t sign a waiver at the beginning of the process waiving their right to object to an eviction if the disabled child moved. Mr. Hunter said this is a strategy that could be engaged but it would involve a certain amount of risk on behalf of the Department because a waiver is not a guarantee. Chair Steinberg asked Mr. Hunter to include and present this idea to the work group.

Chair Steinberg asked if the \$40 million on the Operational Subsidy could be opened up to these families. Mr. Hunter said the \$40 million is essential to make the \$75 million operating subsidy work. Full Service Partnerships MHSA funds can be used to subsidize rent so there is money accessible.

Commissioner Diaz said funds for children cannot be accessed because of the federal matching funds. She was told that families with children of SED would be part of this housing initiative, but now she is being told they cannot because of matching funds. She finds this very frustrating. These families need to have a safe place to live with their children without being evicted when the child does something wrong.

Mr. Hunter said with the right kind of support and intervention available 24/7 to individuals who are renting housing, and building the right kind of relationships with landlords and property managers, people can safely live in housing within the community. It is his hope to take the lessons learned from successfully helping single adults and apply it to the problems of families in order for them to achieve the same success.

Commissioner ? asked what it would take to change the federal regulations. Chair Steinberg said this is something that should be explored.

Public Comments

Patricia Ryan, with the California Mental Health Directors Association, said Commissioner Poat said there is money coming in and it can be spent now if the counties believe there are good projects. Conversely, there are school based health care facilities that can be invested in as well. So should we invest in the current needs or in a visionary concept. Mr. Ryan said from the

county's perspective everyone is working towards the goal of transformation in order to get the outcomes that everyone desires. She said it is better to do this as an integrated plan rather than component by component. She understands it is being done this way to get the services out on the street as quickly as possible and the Department has work to do with all stakeholders in developing the guidelines. As counties and communities develop their plans with the local stakeholders the steps needed to get to the integrated plan will be seen. Each planning process will happen every three years and there will be the ability to adapt what has been learned. There are enough projects associated with adopted CSS plans and other plans moving forward to spend this money one hundred times over.

She told Commissioner Diaz that people are working on dealing with the issue she brought forward and will continue to work hard on putting together a strategy.

Vice Chair Gayle said in the future public comment cards need to be submitted 15 minutes prior to the public comment period.

Chair Steinberg announced that public comments should cover only the specific issues that have been raised over the last half hour and testimony will be limited to one minute. He asked that they repeat what other's have already testified to.

Michael Diehl, said he is a community organizer who goes out and talks to people who are homeless and then advocates for them. He said he appreciates anything that can help get people off the streets. Working with landlords directly has been one way that he has been able to get people off the streets. He helps people work with SSI to learn about living skills. There is concern that consumers have not been included in this process. It is frustrating when people are told something will happen and then it does not happen.

Sandra Marley, said she is a client advocate. As far as police are concerned, there are computer consultants that could set up information where they would have the record flagged to indicate "mental health" so they could have a linkage. She said as far as having consumer access, she is concerned about credit identity theft and in changing client records.

David Keck thanked the Commission for its work. In 2006 he paid 90 percent of his income for rent and then was forced to the street. He lived in a shelter and after 14 years he now lives in public housing. He goes to St. Mary's Clinic which has an automated system where they can track him. He is currently a peer support intern and goes to CSF for a community health worker certificate. He believes the programs will grow and that they are needed.

Fran Edlestein, with the California Alliance, thanked Jonathan and Jane for the work done in the Children's housing. She is happy the Commission directed them to address this issue and it is a good start. A best practices committee would be terrific. She encouraged the Commission to go one step further in the integrated plans for counties and to consider housing for families in their Full Service Partnership. She asked the Commission to give the counties guidelines regarding Capital Facilities. She gave an example where, in counties where providers provide 70 percent of the services that 70 percent of the Capital Facilities, Education and Training, and IT be allocated to the providers.

Gwen Slattery, said Tina Mata, Socorro Ramos, Deborah VanDunk, and Becky have given her permission to use there minutes to speak for all of them. She said she is happy that there is conversation regarding homeless families with children of SED. Once a solution is found there will be a decrease in mental health issues for children as they become adults. She is hoping that some real solutions will occur because solutions like Section 8, with a 10 year waiting list, is not a solution for a six year old. Housing is needed to help these families now. They need to be more involved in treatment issues as opposed to "where am I going to sleep tonight". She hopes

that these conversations don't go on for years, but instead, come to some conclusions that will help now.

Ruth Tiscaneno said she represents the families she works with (tape stops and does not pick up until she has ended her talk.)

Rusty Selix, for the California Council of Community Health Agencies and Mental Health Association, said the Commission is struggling to figure out what its role is and how it should proceed on the Capital Facilities issue. He commented that since the Commission doesn't have the whole program in front of it and the knowledge, while having it locally driven is only there for the component to serve the community support programs now, the score base health centers and other things that might be needed for Capital Facilities for prevention and early intervention is not available now and if the Commission starts that program before the prevention early intervention is fully developed the Commission won't know what it might need to use the money for. The same thing applies to technology and human resources. There are plenty of needs within the community service and supports for all of these, but the point is if the Commission doesn't set aside some money for these purposes they will get left behind.

Chair Steinberg said stakeholders need to be at the table when the capital facilities plans are developed.

Mr. Selix said school facilities are definitely one of the areas. He envisioned there would be more school based services. The others were the gaps in the continuum of care, such as full service partnerships and crisis residential beds.

Michael Wise, with the MHA Health and Wellness Advocates, said in regards to the housing he is a person who has been in the residential care system in San Francisco for 20 years. He believes there is a glass ceiling because people can get into residential care and then go no farther. The homeless problem is certainly number one in everyone's mind, but there is a huge population of mental health clients that are in board and care situations that have no options but to stay there until they are ready for a nursing home and then that's it. He hopes that the Commission can put some attention into this population.

Edmond, LJ thanked the Commission for coming to San Francisco. Making mental health and wellness available to the needy in a multi-media way is necessary. We must appeal to those people who think there is no way. He has been going to a mental health wellness group for two years where he has learned about bipolar, schizophrenia, racism, homophobia, etc.

Ralph Nelson said he hopes the Capital Facilities will include mobile clinics because when you get into the small and rural counties there are very small schools and municipal channels that are not incorporated. They don't need a full time facility, but they do need to have service.

Delphine Brody said the California Network would like to share their comments in writing. There has been a lack of transparency in the MHSA Housing Planning process. Despite the clear mandate in the Act, and in the DMH's own CSS requirements for client and family driven stakeholder process, the Department has thus far neglected to include client and family members in this MHSA Housing Planning process. No clients were involved in the process of developing the MHSA Housing Program Plan; only agency staff. "Nothing about us without us"; this is about us and our housing because we are the ones who have experienced homelessness. There are system-driven requirements in the Housing Plan that violate key MHSA principles that are client driven. These are things that the Network wants changed before it is finalized. The DMH defined the target population of at-risk of homelessness in such a way, that clients who are not exiting foster care, juvenile halls, institutions or jails, must be assessed by and are receiving services at a county mental health department and must be deemed to be at imminent risk of

homelessness as certified by a county mental health director. (Something happened to the tape at this point)

Requiring clients who are seeking MHSA housing to be deemed at imminent risk by the county mental health director will bar many clients who have sought referrals through alternative holistic client-run and traditional cultural ways of healing for MHSA housing. Those direct referrals will no longer be valid unless those programs are funded through county mental health systems.

And, finally, the MHSA Housing Plan requires housing provider applications for housing contracts through MHSA to include a commitment for service funding from the county mental health department and all profits must identify a qualified service provider. This violates two principles: one, the idea that affordable housing should not necessarily be connected with services for clients when clients are not seeing the services, and two, the requirement for qualified service provider is vague, but it seems to imply that such services be staffed by licensed clinicians rather than client-run services staffed by peer counselors and advocates. She wants the client driven elements to be included and the process should allow time for the Network to be meaningfully involved.

Vice Chair Gayle said he would like to apologize for having to rush through the public comments and he will work with the Commission to ensure that adequate family members and client network leaders, and organizations have time on each agenda in order to present their ideas fully.

Dionne Cash said she is a mental health consumer who has been involved in the mental health system since she was 16 years old with her first suicide attempt. She is now 39. As an adult she became homeless as a direct result of her mental illness. Her hope is that no one else will have to experience the discrimination and the torment that she has had to go through in trying to obtain safe housing. She has a 16 year old daughter who she wants to raise in a safe environment with access to good schools. Housing is a basic need and must be prioritized in the DMH Capital Facilities requirements. Housing must be safe, permanent, and affordable. Shelters, transitional housing programs, and boarding care facilities do not meet these standards and should not be considered housing eligible for MHSA funding. More support is needed for clients who live on their own without assistance. Scattered site housing should be a priority in the DMH Capital Facilities requirements rather than clustered housing. Housing should be conveniently located by public transit and shopping.

Steve Leoni, a consumer and advocate said he is concerned that as housing is created and if SRO housing is converted into apartment units people who are living in those SRO's have to leave. He has been told that there is relocation mandated by the State, however there are many loopholes in that process. For example, he has been told that in many instances building owners get wind of this and evict as many people as they can ahead of time so there are very few people left to relocate. Unless you pay attention to increasing the housing stock for affordable housing consumers will be taken out of housing they have now and will be cycled out to homelessness and back in. He asked the Commission to pay attention at the state level in making sure this type of round robin door does not happen.

VII. Co-Occurring Disorders: Report & Recommendations

Chair Steinberg said this item will be deferred until the May meeting.

VIII. Updated MHSA Timeline, Revenue, and Expenditures

Commissioner Poat gave the following report:

This report will track the following three items:

- MHSA funding forecast
- Component program allocations
- Expenditures and balances for component programs

Changes since the last report:

- The funding forecast increased revenue projections from January budget versus last fall
- Policy change: Housing program funding
 - CSS funding source rather than “off the top”
 - CSS prudent reserve updated – Housing NOT considered a service
 - Anticipate inaugural funding July 2007
- Distribution dates for three additional programs now projected
 - Capital Facilities/IT
 - Workforce & Training
 - Prevention & Early Intervention
- First planning cycle extension from three to 4 years

MHSA Fund Forecast

- The Governor’s January budget proposal forecasts revenues during the first five year planning cycle increasing from \$1.2 billion to \$1.9 billion
- Revenues were expected to be \$3.14 billion, then new information came along suggesting that there would be \$4.3 billion, and now the new projections are for over \$5 billion. There are more revenues than previously anticipated by \$1.9 billion.

Component Program Funding

- The CSS program funding now reflects \$115 million annual support for housing program
- Additional spending in two component programs are CSS and Administration are now being spent
- There are new expenditure projections for three programs: Capital Facilities/IT, Education & Training and Innovation
- There was no major activity with new expenditures in the area of planning.

Programs Committed & Spent

- Community Services and Supports (including Housing) have actual revenues of \$773.8 million with actual expenditures of \$510.4 million. Estimated committed additional expenditures are \$251.5 million (\$114.5 million for Housing Program), contribution towards prudent reserve is \$35.7 million and is over subscribed by \$23.8 million.

Chair Steinberg said the actual expenditures are the amount expended from the state to the counties, but not necessarily from the counties to the programs. He asked if there is a breakdown of how much of the \$510.4 million is out in the community from the county. Ms. Hood said she does not have that information now, but there are two ways in which she will get that information: from a quarterly report that will be received by the counties and at the end of July counties will provide a cash flow statement. This information will be provided to the Commission once it is received. Commissioner Poat said he will add another column to his report “Expenditures by the County” for the next meeting. He then continued his presentation.

- The money for local planning has been spent.
- There is a balance in the State Administration which is generating interest and it raises the question of “Should we be doing something more with this money to accelerate the implementation of the Act?”

Chair Steinberg said the Commission ought to have sufficient staff to review Intervention Early Intervention Plans and to provide its oversight role in the most appropriate way. Commissioner Poat said there are two policy issues that come up: (1) the \$23.8 million that is oversubscribed

(more obligations than there are revenues) in CSS and (2) the question of the balance in the State Administration fund.

- There are several programs where funds are not being expended yet, but the good news is that target dates are being received for these programs now.
- Conclusions:
 - The fund administration is still in a “start Up” mode – the necessary result of public planning processes
 - To date one component is on track for full expenditure and that is the Local Planning money; One component is slightly over-subscribed and that is the CSS funding; one component has funds available and that is the State Administration with \$44.2 million.
- Four Programs now have timelines by which to move from planning to expenditures
 - CSS Housing Initiative
 - Education & Training
 - Capital Facilities/Technology
 - Prevention and Early Intervention
- Two programs remain with no timeline for expenditure
 - CSS Innovation
 - PEI/Innovation

Commissioner Diaz asked what the term “oversubscribed” means. Ms. Hood said there are a number of items in CSS where there are commitments for the year, but there are not revenues for the whole year as yet. At the time the information was given to Commissioner Poat the revenues were through February 28. She is confident revenues will keep coming in for the balance of the year.

- Prudent Reserves
 - Previous decision: There will be a prudent reserve equal to 50% of services. It was previously assumed that CSS would be 100% services provided to clients but with the addition of the housing program, it will be treated differently. The CSS Housing Program is not a service.
 - Reserves will be based of FY09 and there will be a higher rate of reserve for CSS because more money will be spent on CSS programs based on the allocation established in the Act.
- Policy Issues
 - Issue of MHSA Housing Program cost allocation to CSS
 - Proposal to fund 5 years of permanent supportive housing out of the CSS program: \$75 million per year for 5 years, a \$375 million commitment
 - Proposal to fund operating subsidies
 - \$40 million per year for five years would be \$200 million commitment
 - Funded through unanticipated revenues
- Next Steps
 - Next Revenue update will be with the May Revise. The Governor issues a budget proposal in January premised upon a variety of financial assumptions. The Department of Finance does the May revise depending on the economy and tax revenues.
 - Program Definitions
 - The CSS and PEI/Innovation Programs are still moving through the development process. There is additional work to be done in the area of outcomes definition and adopting a regular Commission report card.
 - Supplantation

- MHSA funds within larger Mental Health Program Funding context
- 05/06 unanticipated revenues spending plan for non-CSS programs.

Commissioner Poat said revenues are doing well and more programs are being developed to start spending the money. He will report back to the Commission after the May Revise.

Chair Steinberg said that under CSS for the estimated additional expenditures there will be \$135 million of additional funding. He asked what the Department's intention is regarding this \$135 million. Ms. Hood the Department is looking at trying to pre-fund (set aside out of current revenues) some housing up to \$400 million. She also wants to be sure that prudent reserve is funded by the time the Department gets to the integrated plan. The Department will wait until the May Revision to determine the status and see if there is money for additional expansion. The formula will not be changed. One of the reasons the Department does not currently include housing is because there is no database that currently affects all counties.

Commissioner Dobson asked if the \$86.7 million for State Administration is through February 28 or through 6/30/07. Ms. Hood confirmed that it is through February 28.

IX. MHSA Emergency Regulation Overview

Ms. Hood provided the following overview:

- There is a hierarchy. Regulations are requirements that the counties must abide by, but if there is a conflict between regulations and statute, statute would be primary over that. The Hierarchy is:
 - Constitution
 - Statute
 - Regulation
 - Policy Guidelines
- There was the initial version of Emergency Regulations (MHSA 1) and then a more thorough next version (MHSA 2) replaced MHSA 1.
- MHSA Regulations can be found in the California Code of Regulations, Title 9, Division 1, Chapter 14.
- The difference between MHSA 1 and MHSA 2 is that definitions are expanded and establishes requirements that apply to all categories, reporting requirements, mechanism for use of alternative programs, and requirements specific to CSS.
(Detailed analyses of the differences were handed out to those present.)
- There are two issues that people are focusing on regarding MHSA 2:
 - Article 4: Programs/services – previously it was said that programs needed to be voluntary in nature. The Office of Administrative Law thought that not everyone would interpret that as being the same and might not come to the same understanding. The language was clarified but the intent is not changed. What is being said now is that programs and services “Be designed for voluntary participation. No person shall be denied access based solely on his/her voluntary or involuntary legal status.”
 - Article 6: The issue here is where there is a potential conflict in the Regulation. Under the full service partnership what is said is that the county can pay for whatever it takes. Sometimes in people's recovery hospitalization is required and what is implied is that the cost of hospitalization could be covered through full service partnership because there were no limits. However, in Article 4 it states “designed for voluntary participation” and almost all hospitalization is not voluntary. The position the State took is that the county may pay for short-term acute inpatient services (not to exceed 30 days) only for clients in Full Service Partnerships and only when the client is uninsured for this service or there are no other funds available for this purpose.

- Next Steps
 - Finalize MHSA 2
 - Public Hearing April 16, 2007, 1:30 p.m. at 744 P Street, Room 102, Sacramento
 - Written comments by 5:00 p.m. April 16, 2007
 - Adoption of permanent MHSA 2 regulations
 - Other MHSA regulations to come – E/T, MHSA Housing, Capital Facilities, etc.
 - Continued collaboration and training.

Dan Brzovic, Associate Managing Attorney, Protection and Advocacy, Inc. spoke about the regulation issues around voluntary and involuntary services. He explained that services must be provided on a voluntary basis, although the MHSA does refer to people who have to sometimes be hospitalized, there is a difference between providing MHSA services on a voluntary basis to people who are in the hospital and paying for the hospitalization itself. Involuntary hospitalization is not authorized by the Act.

The counties are obligated under realignment to pay for involuntary hospitalization for people who cannot afford it. Realignment was designed to give the counties flexibility in funding mental health services, but it does not give flexibility when it comes to paying for involuntary hospitalization. This is something that counties are already required to do under existing law so the MHSA funds in being used to pay for involuntary hospitalization would be supplanting a current county obligation.

Mr. Brzovic will submit his written comments to the Office of Administrative Law in its review process. He said he appreciates that the Department of Mental Health is trying to clarify its language on voluntary service, but he believes the language could be clearer still if it focused on individuals actually consenting to services.

Chair Steinberg asked if, in Mr. Brzovic's view, that what is being proposed is supplantation. Mr. Brzovic said in the area where the MHSA refers to services being provided to people on involuntary status, and if MHSA money is used for that involuntary hospitalization itself, it would be considered supplantation. All of the services must be voluntary.

Ms. Hood said it is her understanding that counties do not have the obligation to pay for the hospital services. Realignment is to the extent resources are available.

Pat Ryan said having represented both hospitals and counties, there is a difference between a county's obligations to administer the Lanterman-Petris-Short Act. They have the obligation to oversee and designate hospitals to the 51/50 facilities. Someone being involuntarily hospitalized does not obligate a county to pay for that hospitalization. Counties do not have an obligation to pay for hospitalization, whether voluntary or involuntary, for someone who is uninsured. Some counties will pay, depending on resources available.

Comments from the Commission

Chair Steinberg said an important fact that the Commission needs to know is how many counties, prior to the passage of the MHSA, provided funding for hospitalization and in what amounts, because if counties are now going to say they are not going to do what they previously did, this then would indicate the supplantation. Ms. Hood said she can look at the cost reports that counties have submitted and get this information to the Commission.

Vice Chair Gayle said if the Commission does not know how many counties pay for indigents' hospitalization prior to the MHSA then he doesn't see how this conversation can continue. Chair Steinberg said he will ask the Department not to approve this portion of the regulations until the Commission has had a chance to review the information.

Commissioner Feldman asked what the intent of the Legislation was with regard to this particular issue. Given how controversial this issue is, the Department will make a special effort to highlight it in information they send out to stakeholders.

Commissioner Doyle said even if there is not a supplantation issue there still seems to be an issue about using MHSA funds for involuntary hospitalization. Mr. Brzovic said there is an issue about using the funds for involuntary hospitalization because when the MHSA refers to the Lanterman-Petris-Short Act in people who are involuntarily hospitalized, it is referring to the status of the individual and there is no obligation to pay under that section of the MHSA.

Commissioner Dobson said the Commission needs to look to what the peoples' intent was with regard to this initiative. As he understands it, these regulations are Emergency Regulations and there are deadlines.

Commissioner Chesbro said there is more than a legal issue, in that there is a history of when the mental health community is divided and when they are unified. Prop 63 is a prime example of when they came together in unification and so there is this political element, as well as the legal issue.

Chair Steinberg said that under the law the hospital has to take the patients, but the counties do not have to pay. However, some counties have paid for the services without insurance or Medi-Cal. There are two issues: (1) what has the practice been; and (2) whether or not the Act, regardless of supplantation issues, allows the money to be spent on involuntary care. He asked that when people are making comments to distinguish between the two separate issues.

Commissioner Gayle said he believes the Act was formulated to promote wellness and recovery and to say it is all right to spend money for involuntary services, such as hospitalization, is opposite of what the Act was formulated for and this doesn't make sense to him. Chair Steinberg said in making a fair assessment and recommendation, the question regarding the policy of who pays, must be clear.

Public Comment

Delphine Brody, said the California Network of Mental Health Clients is strongly opposed to Section 3620K of the Emergency Regulation because it violates the letter and the spirit of the Mental Health Services Act and runs counter to the principle of client and family driven recovery based services. The Network also feels it is discriminatory and stigmatizing to all mental health clients, and as such, it threatens to erode clients' trust in the MHSA and its possibilities for real transformation.

If CSS fails to deliver the outcomes detailed in the requirements, but in fact produce the opposite result, the failed program should be held accountable. Involuntary hospitalization of any length will be a bad result based on the very goals of the CSS requirements of the DMH and of these regulations. This bad result will be a program failure and programs should not be rewarded with more funds for failing the goals of the MHSA. Allowing funds for hospitalization will provide incentives for involuntary treatment. The provision to allow MHSA funds for hospitalization will inevitably lead to involuntary treatment within hospital settings and the treatment will follow the funds.

Furthermore, to allow counties to use MHSA monies to involuntarily hospitalize MHSA clients will only encourage many more failures of this nature and sets the stage for the complete undoing of much of the transformation promised in the Act and prescribed in the requirements. Thus any initial failure of an individual county that leads to the use of MHSA funds for hospitalization

under this provision will usher in an unwanted and unprecedented resurgence of failed first public policy. This will erode client trust which is an essential element.

Sally Zinman, Executive Director of the California Network of Mental Health Clients, spoke to why MHSA funds should not be used for involuntary hospitalization or short-term hospitalization. Ms. Hood referred to “whatever it takes” and Ms. Zinman’s understanding of “whatever it takes” is that the treatment plans are designed by the consumer so whatever it takes is client driven, not provider driven. “Involuntary” means clients do not want it.

If MHSA is working there will be less people in hospitals and not more. One of the goals in the very regulations itself is to decrease hospitalization.

Consumers avoid the system because of hospitalization. MHSA provides opportunities to create new alternatives and options that are voluntary, i.e., crisis residential facilities, in-home support, etc.

Michael Diehl, with the California Network of Mental Health Clients, said there is a basic violation of the consumers’ understanding and trust of “whatever it takes”. He goes out into the streets to enroll people in the First Service Partnerships and is going to have difficulty enrolling people if they believe they are going to get hospitalized. He has helped 50 people from the streets get help through their crisis and the only suicide was from one who was put in the hospital.

Richard VanHorn, with the Mental Health Association, said 19 years ago a piece of Legislation was passed to establish an adult system of care. The pilot for this project said “you have to do whatever it takes”. It needs to be in one location, easily accessible, treat the range of people with major mental illness, and be responsible for every dollar it spends.

He said the current discussion over hospitalization is that no one is responsible for the dollars other than the county or the hospital, therefore there is much more hospitalization now than in the pilot years of 1990 to 1996. The original plan was to have a small crisis house as a part of this program but unfortunately they currently do not exist around the state.

The issue facing us now is are we going to jettison the goals in the Act and, settle for 30 days of involuntary care, or are we going to revert to some kind of real responsibility for the dollars spent and put the risk back on the provider and establish the crisis houses which are a much better solution.

Rusty Selix, said something very complex has been tried to be covered in a simple statement and it just doesn’t work. On the surface there is no prohibition on somebody who is in a Full Service Partnership which is the main type of service it funds. Ms. Zinman made a good point that when this is done there will be less hospitalizations. With less hospitalization the supplantation rules should prohibit a county from being able to use these dollars. They cannot use these dollars unless they have more hospitalizations than they had previously because otherwise it is a form of supplantation.

Each county will be different, and in nearly all circumstances, it is not likely that the Act is going to be able to pay for 51/50 because the counties do pay for most of them. He believes a lot of furor has been created over something that is a few and far between situation.

It was brought up by a Commissioner that there was a discussion that there were two problems with this proposal: (1) that the Act itself could not fund this type of activity and; (2) supplantation. He asked Mr. Selix if he was stipulating that there is no direct prohibition in the Act for this funding. Mr. Selix said there is no prohibition if it is part of a Full Service

Partnership. People in Full Service Partnerships, which are voluntary programs might, while they are in that voluntary program, need a hospitalization which might be involuntary.

Commissioner Feldman said in addition to the supplantation issues and legal issues, there are clinical quality issues as well. There is no doubt that there is a wide variety of high-quality clinical approaches and alternatives to inpatient treatment that are better. The significant issue for him is that there are better alternatives.

Ralph Nelson, said he is speaking for himself as a father and consumer. His concern is that the Mental Health Services Act has said to the counties, go out and get all the unserved and underserved people and bring them into your system, and it will be paid with Full Service Partnerships with Cadillac services “whatever it takes”. However, when it comes to the hospitalization, which is the most expensive part of it, then they say the traditional system can pay for it. He finds this very discriminatory. He is not in favor of taking money out of the traditional system, realignment funds and county funds, to pay for people who are a Full Service Partner and who have already gotten Cadillac services and now need hospitalization.

Ruth Gravitt, said she is a consumer. San Francisco is in a unique situation and asked that the formula not be applied to San Francisco County as it is to other counties. San Francisco is teeming with the homeless and more money is needed for better crisis teams and better training. She is currently working with Angela Alioto who is working on a ten year plan to help the homeless. She will interface with her group, the state, and city to solve the problem of the allocation formula and the money for the homeless.

Bob Savi (? Sp), Director of Community Behavior Health Services in San Francisco, said it is essential that the money be released and available in all the categories. He would like to have a mechanism to apply for additional funding as additional needs are identified. The homeless issue was never addressed, and the Bay area is a magnet, because it is accepting of people’s behavior that may not be well accepted in other counties. There is a higher incidence of mental illness which needs to be factored in when looking at the need, and drug and co-occurring disorders is a clear factor. San Francisco integrated mental health systems and it has recognized that where there is high drug use there is also high mental health problems.

He is concerned that counties who have been working with the public in using their general fund and tax dollars in a socially conscious way were, in a sense, punished by having too many services. San Francisco has an indigent care system that is equal to Medi-Cal, including full pay for hospitalizations. They have also recognized the role of primary care that will support the mental health strengths of its clients. The Bay area is quite diverse in cultural needs with many different kinds of people in a very concentrated area. He would like to see that whatever monies are available are released as soon as possible, and that there be a mechanism to apply for any additional resources.

Jeffrey Giompetro, a member of the California Network of Clients in San Joaquin County, said the involuntary hospitalization and cost of the overall 30-day stay is excessive and the Mental Health Service Act funds should not be used for involuntary services because funds will run out. From a consumer’s point of view, the outreach being done to target populations will not work with the funding of hospitalization hanging over their heads.

Mitch Katz, said he is the San Francisco Health Director and clinician who cares for people with serious mental illness. He said there is an urgency to release additional funds. It is his understanding that there are resources that have not yet been let out and he cannot yet apply. In his county there are many people who would benefit from this money and the county system is ready to do this today. There are currently 200 people in a Full Service Partnership and he is ready today, to enroll 1,300 people in a Full Service Partnership if the money were released.

Katherine Bond, a member of the California Network of Mental Health Clients, said she is one of those people who would rather be on the street than in a mental hospital. She said going into a hospital is not a helpful environment. It does not heal, or invite her into wellness. When she was getting petitions signed for the Mental Health Services Act she was reaching out to unserved and underserved people, and these people were not interested in hearing about going into hospitals. They wanted to hear about a transformation of the Mental Health System that would respect them as human beings. She, or any of the unserved and underserved, are interested in supporting a regulation that increases the possibility of them being involuntarily hospitalized.

Noel Startment (sp?), said she wanted to talk about supplantation and maintenance of effort. She just came from the Santa Clara County Health and Hospital Committee where the mental health budget was discussed. Santa Clara County serves about 18,000 consumers and this year the county is facing a large budget shortfall. Mental health was given a large target because, traditionally, it did not have homeless people with mental illness as seen in other places since Santa Clara County provided, through the general fund, beyond what was prescribed by realignment Legislation. The target was given to Santa Clara County when the overmatch was given through the regulations, and as a result 8,000 of the 18,000 will lose their services, four to five clinics will be closed, and the end result is people are asking what has been done with the money from Prop 63. She fears that Santa Clara County will truly suffer with this interpretation of supplantation and maintenance of effort, not only in the traditional services but MHSA will suffer as well.

Robert Williams, from Santa Clara County and NAAMI Vice President, and member of the Mental Health Board, asked the Commission for its action. He asked that DMH withdraw their interpretation of supplantation. He said because a bureaucracy cannot move fast he asked that the Oversight Committee write a letter to Santa Clara County saying they are in danger of losing their Mental Health Services Act money if they go ahead with their budget plans, which is not only cutting \$34 million of direct county overmatch but imposing another \$14 million because of the higher use of the intensity of services. He encouraged the PAI (Protection and Advocacy Inc.) to file an injunction to delay the cut until the MHSA can be clarified.

Paul J. Quinn (sp ?) said he is a member and Director of the Depression and Bipolar Board Alliance. He has heard a number of people speak today of how their budgets will be cut by upcoming Legislative action. His group gets no money focused for this disorder, even though it costs billions of dollars in lost work time, because typically depressives and bipolars are high performing professionals who work above normal capacity because of their disorder. The only time the Mental Health System acknowledges them is when they triage them at emergency rooms if they are not successful in their suicide attempt. The nature of the bureaucratic structure in getting money to fund any outreach and intervention program to serve these people, who both reject the idea that they are mentally ill and do not want to be looked down upon by their peers as mentally ill, prevents any kind of meaningful outreach. What they need is total anonymity and somebody to consult with in total anonymity, who is not a professional, and will listen and understand what they are saying,

There is no way to get this done in the bureaucracy because of the accountability practices. You cannot have an anonymous service and show that it is working. Nothing has been targeted towards depression and bipolar support so his group exists entirely on donated funds. The methods that are being used to find the unserved and underserved are useless in terms of depressives and bipolars.

Chair Steinberg said in the Full Service Partnerships, approved by the Department and overseen by the OAC, there are many people who are being served who are living with bipolar disorder and major depression. He feels that it is an overstatement to say that those with depression and

bipolar disorder are not being served by the Act. Mr. Quinn said he was not saying that they were not served, but that there was no focus effort with anonymity as the key.

MOTION: Commissioner Chesbro moved to communicate through a letter opposing Article 6, the Proposed Emergency Regulation for funding of involuntary hospitalization for those not covered by insurance or Medi-Cal, including but not limited to the concerns of supplantation and the spirit of transformation that is the intent of the Act; seconded by Commissioner Doyle.

Chair Steinberg asked Commissioner Chesbro if he would be willing to take the following friendly amendment to the motion: “That the OAC would oppose Article 6 for two reasons. (1) Concerns about supplantation whether legal or practical. (2) That the OAC does not believe that given the limited resources contained under the Act that resources should be spent on the cost of hospitalization.”

Commissioner Prettyman asked what is meant by short-term 30 days. She said short-term is 72 hours, not 30 days.

Chair Steinberg said he supports the motion. He attended a meeting of the probation officers who asked why the MHSA could not pay for services for the kids who are in the juvenile system and who are not receiving decent mental care or treatment. He had to tell them that the Act could not pay for their care, and that other institutions of government would have to step up and provide the funding to do this. If we begin funding things that are inconsistent with transformation the door will never close. There is not enough money to help all the people in need and he believes the Commission needs to pass this motion and send a message to the Department that we should not open this door.

Commissioner Poat said he is going to oppose this motion because he does not believe the Commission is equipped to make care decisions and he does not feel comfortable making a decision today. At some future time, if this can be reviewed and a long-term policy is set of what is acceptable as an effective form treatment then he would feel more comfortable. To him, the question today is, who gets to decide and he wants to leave that decision in the hands of mental health professionals at the county and advocacy level and a variety of other levels.

Motion carried with 8 ayes, 4 abstentions and 1 nay.

IX. MHSOAC Supplantation/Maintenance of Effort Work Group Recommendations

Commissioner Chesbro said, at the last Commission meeting, there was direction to create a working group on supplantation. Another word the group is using is “erosion” because there are related issues that cannot actually claim to be supplantation. The question of supplantation and erosion is going to become a permanent part of this Commission’s role because there are an endless number of potential variations that will be seen over time.

Sheri Whitt provided the following presentation:

The first issue the work group considered was is there enough protection and oversight at the state level to prevent supplantation? One of the examples that were looked at specifically was is maintenance of effort clearly defined enough and is the proposed elimination of AB2034 an example of supplantation?

The work group came to the conclusion that clearly there is not enough protection and oversight at the state level to prevent supplantation. The work group did believe that supplantation, incursion and maintenance of effort issues pose the single largest threat to the successful implementation of the Act. They felt that maintenance of effort was clearly defined enough in the

Act, but interpretation as represented in the DMH Emergency Regulations themselves was not clear enough.

The **proposed motion** for the Commission's consideration is: "That OAC advocate for DMH to change the language of the DMH Emergency Regulations to more clearly define maintenance of effort. The process to make this happen would be for the OAC to submit written testimony and make public comment on April 16, 2007 public hearing.

Commissioner Chesbro pointed out that a number of the members of the working group felt that the counties were not seriously considering doing this until the Department of Mental Health pointed an arrow in a certain direction and said in these Regulations that it is going to be allowed and this caused a light bulb to go on and say, "Oh, that's an option". There is a feeling that that door needs to be closed.

Ms. Whitt said the two sub-questions to the issue are that the proposed elimination of AB2034 is clearly an example of supplantation. The work group is recommending sending the attached letter to the Assembly Budget Chairs, and also proposes that in the contents of that letter there be some language talking about the fact that elimination of Children's System of Care funding was also a supplantation issue that went largely unaddressed at the time the funding was eliminated. So the intent was to address both the proposed elimination of AB2034 and also to backtrack again and address the fact that the Children's System of Care funding elimination was inappropriate as well.

Proposed motion No. 2: Send a letter to Assemblymember Patty Berg, Assembly Budget Sub 1 Chair and Senator Elaine Alquist, Senate Budget Sub 3, Chair under signature of the MHSOAC Commissioners formally rejecting the Governor's proposed elimination of Integrated Services for Homeless Adults with Serious Mental Illness (AB34/2034).

Chair Chesbro said he is optimistic about the Commission's ability to prevent AB2034 erosion/supplantation from happening in the budget. The working group felt it was important to take a stand to let the Legislature know as well as the various constituents. The work group felt it important to let the county know that they felt equally as strongly if it is the state is doing this as they do if it is the county doing this.

MOTION: Commissioner Chesbro moved to send a letter to Assemblymember Patty Berg, Assembly Budget Sub 1 Chair and Senator Elaine Alquist, Senate Budget Sub 3, Chair under signature of the MHSOAC Commissioners formally rejecting the Governor's proposed elimination of Integrated Services for Homeless Adults with Serious Mental Illness (AB34/2034); seconded by Commissioner Dobson.

Discussion

Commissioner Diaz said there was no reference in the motion about the Children's System of Care. Ms. Whitt said that there is reference to this issue in the letter which is in the Commissioner's packet.

Commissioner Poat asked what the justification is for not funding AB2034. The Governor's proposal will eliminate all funding for AB2034 programs and in doing so he noted that "similar services are available to individuals under Prop 63". This seems as though it is supplantation. Chair Steinberg said the Governor's rationale was the ongoing budget deficit. The justification was that the overall level of mental health funding did not decrease given the increase in EPSDT and so there was not a violation of a maintenance of effort, but it is a clear supplantation.

Commissioner Poat asked if there was any hope that in the May revise there might be a funding adjustment to this program. Chair Steinberg said it may be possible. Commissioner Poat said his request would be to send a letter to the Governor stipulating that this Commission believes the program is important and then the May revise is the opportunity to fund that program.

Ms. Hood said that the Administration believes that the obligation under the MHSA is a maintenance of effort that is in aggregate and that the State needs that test through expansions they have had through 2003/2004 which was specified in the statute. Administration does not believe that there is a supplantation test for the state; it is a local test about whether or not the same services are being provided. If the locals were providing 2034 services through these funds they could no longer continue to provide those exact same services and there is nothing that prevents the State from reducing the funding.

It was stated that at the local level there are no funds to use.

Chair Steinberg said the Act is very clear that supplantation is to be considered program by program and not an overall aggregate of the spending on mental health.

ROLL CALL VOTE FOR MOTION ON THE FLOOR: Motion carried with 10 ayes and 2 nays.

MOTION: Commissioner Poat moved to write a letter to the Governor requesting that the funding be restored to AB34/2034 and the letter should extol all of the success of the program and that by taking money away from the counties forces them into a situation where they have trouble with supplantation; seconded Commissioner Kolender. Motion carried unanimously.

MOTION: Commissioner Chesbro moved that OAC advocate for DMH to change the language of the DMH Emergency Regulations to more clearly define maintenance of effort. The process to make this happen would be for the OAC to submit written testimony and make public comment on April 16, 2007 public hearing; seconded by

(Tape stopped and was turned over and begins as follows.)

Ms. Whitt continued her presentation:

Issue 2: Who has the role for enforcing adherence to supplantation regulations at the state level? The work group was not able to develop a complete answer to this question during its meetings but was clear the Commission has a critical role in proposing strategies and approaches regarding enforcing adherence to supplantation regulations. There is a clear intent, as stated in the Act, that MHSA dollars were to expand mental health services and it can be accurately assumed this is what California voters intended when they passed the Act. Section 5845, (6) of the Act stipulates the Commission may “At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness”. The Commission has a responsibility to inform the Governor and the Legislature when we have concerns related to supplantation and maintenance of effort. The work group is proposing creation of an ongoing OAC Mental Health Financing Technical Resource Group to help fulfill this responsibility.

The **proposed motion** is to create a MHSOAC Mental Health Financing Technical Resource Group (MHFTRG). The charge of the MHFTRG will be to identify public mental health financing issues that impact MHSA implementation and recommend to the MHSOAC actions it may take to ensure the objectives of MHSA (mental health systems transformation and program expansion) are met.

Public Comment

Richard VanHorn said he believes the motion should remind the Governor that the Commission is asking him to restore this because there are 4,800 people who are being served for whom there are no county dollars to serve them. Secondly, he should be reminded that the model programs in three counties, which was the basis for doing this initiative, would be eliminated.

Speaker ?? motion 1 should have an additional provision in it because to send something back and ask the Department of Mental Health to use the Regulation is not going to be timely compared to the budget hearings to supervisors. The motion should say that we believe that the DMH regulations mis-states the intent of the Mental Health Services Act with respect to supplantation. Chair Steinberg advised that there will be more detailed information presented that will raise his concern.

MOTION: Commissioner Chesbro moved to create a MHSOAC Mental Health Financing Technical Resource Group (MHFTRG). The charge of the MHFTRG will be to identify public mental health financing issues that impact MHSA implementation and recommend to the MHSOAC actions it may take to ensure the objectives of MHSA (mental health systems transformation and program expansion) are met; seconded by Commissioner ?

Commissioner Poat said he does not feel comfortable adding another technical committee when he believes the focus should be on getting the money out the door. Commissioner Chesbro said in the short-term getting the money out is the highest priority, but in the long-term, for the existence of the Act, there is no single higher priority than monitoring questions of erosion and supplantation. He believes it is a core function of this Commission to monitor this issue.

It was asked if in the motion it should specify who will be on the group, when it will meet, and how much resource would be needed. Chair Steinberg said the Commission can either approve the motion now and come back in May with a strategic plan for the Committee, or the motion can be put off until May.

Commissioner Chesbro said he would withdraw the motion and direct staff to work with the Chair, and any interested Commissioners, to develop a proposal for the May agenda.

Ms. Whitt continued with her presentation. Issue 3: Counties are able to transfer 10 percent of realignment funding out of their mental health budget each year. This could be an area of supplantation vulnerability. This was an area of much discussion and concern. There are those who support language in DMH Emergency Regulations limiting the transfer of realignment funding to 10 percent and view it as a protection of funding which might otherwise be transferred out in larger amounts and there were others who believed that the 10 percent limit cited in the regulations gave tacit approval to the California County Boards of Supervisors to make realignment transfers. They thought they might not otherwise make them if that figure was not in the regulations.

The **proposed motion** is to refer this issue to Mental Health Financing Technical Resource Group because it was realized in the meetings the work group had there was not sufficient time to come to a conclusion. Chair Steinberg said this issue should be brought to the next meeting.

Issue 4 has to do with some County's Boards of Supervisors providing more than required levels of funding in their counties for mental health services (overmatch). The work group feels this is clearly an area of supplantation which they propose addressing in two ways. The work group believes that Emergency Regulation language needs to be changed to be more aligned with the language in the Act. In addition, the work group proposes sending the attached letter to the

California County Mental Health Director's Association and to the California State Association of Counties outlining the Commission's position regarding this issue.

Ms. Whitt reviewed Motion 1 and 2 and said the work group is interested in **Proposed Motion #2**: Send a letter to Patricia Ryan (Executive Director, California Mental Health Directors Association), Don Kingdon (Deputy Director, California Mental Health Directors Association), Mark Refowitz (President, California Mental Health Directors Association), Frank Beigelow (President California State Association of Counties), with a copy to Stephen Mayberg (Director, Department of Mental Health) and Kim Belshe (Secretary, California Health and Human Services Agency clearly stating the Commission's opposition to all forms of supplantation.

It was requested to send letters to all the counties as well.

Commissioner Diaz said, the way she understands it, is that it is the Board of Supervisors and not the Directors that are doing the maintenance effort. She asked why then is the letter being sent to the Directors. Chair Steinberg said the letter should be sent to all interested parties, to include the County Supervisors, Mental Health Directors, County Executives, Sheriffs, Department for the Rule Making, etc.

Chair Steinberg reiterated that the Act specifies that there shall not be a reduction in funding at the County level and this is exactly what happened in Santa Clara County as a result of the initial Department Emergency Regulation which allowed them to go down to the maintenance of effort.

Commissioner Poat said the question he has is whether the Commission is going to start assigning definitions for elected officials who have to make tough choices. He does not find a great value in the Commission spending time re-visiting decisions made by elected officials. Chair Steinberg said they have not made the decision. He said county supervisors have the right to make cuts, but if they do make cuts, does the Commission provide MHSA dollars to essentially supplant their decision to cut.

Commissioner Poat asked why the motion wouldn't be focused on the Commission's policy rather than encountering this situation. It was pointed out that the Commission must explain what the basis is for it withholding funds. Commissioner Poat asked what overmatch means. Chair Steinberg said it means they had a certain level of funding prior to the passage of the Act and then they reduced the funding after the passing of the Act. The question is what the level of services were that were in place at the time of the passage of Prop 63.

Commissioner Lee said he feels there must be some mechanism to provide positive feedback to a county who has made a conscious choice to program dollars from other areas within their county to support the mental health services. He also believes that the level of service that occurred in 2004-2005 must be maintained, but as we move forward into the future, perhaps, they can be given credit for that money as a part of a match.

Commissioner Chesbro pointed out that the work group did not characterize this action as unanimous because the county representatives who were a part of the work group did not agree with this.

Public Comment

(Speaker not identified). She felt this needs to be done sooner rather than later because in order for her county to get the budget decisions by July 1 they have to start action in April because discharging 8,000 people from services and closing clinics has to be done over time.

MOTION: Commissioner Chesbro moved to send a letter to Patricia Ryan (Executive Director, California Mental Health Directors Association), Don Kingdon (Deputy Director, California Mental Health Directors Association), Mark Refowitz (President, California Mental Health Directors Association), Frank Beigelow (President California State Association of Counties), with a copy to Stephen Mayberg (Director, Department of Mental Health) and Kim Belshe (Secretary, California Health and Human Services Agency, County Boards of Supervisors, County Executives, Sheriffs, and the Department for the Rule Making clearly stating the Commission's opposition to all forms of supplantation; seconded by Commissioner Henry. Motion carried.

Commissioner Chesbro said there were additional issues that the work group discussed. One was Incursion and the other was work force issues. He said there was no reason to have a detailed discussion today and asked that they be folded into the direction for staff.

MOTION: Commissioner Chesbro moved to send the letter to Senator Elaine Alquist, Senate Budget Sub 3, Chair, notifying her the Commission supports restoration of the 5 percent provider rate reduction imposed on county Mental Health Plans in FY 2003-04 and supports providing for needed cost of living adjustments (COLA) for this program; seconded by Vice Chair Gayle. Motion carried.

Commissioner Dobson asked what if Mental Health Act funds are used for this. Commissioner Chesbro said then that would be supplantation. Commissioner Dobson said that isn't stated and asked if this is with regards to the general funds. It was affirmed and Commissioner Doyle (?) said tomorrow when he talks about work force and training issues he will roll this in as part of a non-supplantation piece of what he proposes to send to the Governor's office.

X. Adjournment

The meeting was recessed at 5:30 p.m.