

COMMISSION MEETING MINUTES
Friday, June 15, 2007

I. Call to Order

Chair Steinberg called the meeting to order at 9:00 a.m.

II. Roll Call

Present were Commissioners Wesley Chesbro, Carmen Diaz, Paul Dobson, Jerome Doyle, Linford Gayle, Mary Hayashi, Patrick Henning, Jr., Karen Henry, Kelvin Lee, Andrew Poat, and Darrell Steinberg

Absent at roll call were: Commissioner Saul Feldman, Gary Jaeger, William Kolender, Darlene Prettyman

III. Student Mental Health Initiative (Action)

MOTION: Commissioner Dobson moved to fund the Student Mental Health Initiative for \$30 million for higher education and \$26 million for K-12 over four years; that the Department and staff report at the July meeting with a proposal and vote for the grant requirements; the Department and OAC staff work with the various stakeholders to help develop the guidelines in a way that reflects the intent of the initiative as described; seconded by Commissioner Doyle.

Commission Discussion

Commissioner Diaz said her concerns are: (1) what is the difference between this initiative and AB3632. Chair Steinberg said this is going to be training, peer-to-peer support, development of infrastructure to be able to deliver more effective mental health services at the K-12 and higher university level, as opposed to direct services. (2) Why can't this go through counties? Chair Steinberg said this money was part of the statewide set-aside already agreed to by the government partners for stigma, discrimination, and suicide reduction. The counties are supportive of this initiative. (3) If for some reason there is not a consensus among stakeholders or this committee on the process, can this money be put back into the regular statewide programs? Chair Steinberg said the intent is to deliver on an education mental health initiative. This is a beginning and not a substitute for greater collaboration and strategies that integrate the K-12 system, the county mental health system, and the Act. This money is not intended to be pulled back for other purposes.

Commissioner Hayashi said she is supportive of this initiative but it is important for the Commission to have some sort of baseline or goal of reducing stigma and discrimination.

Commissioner Dobson said he would expect a level of funding at the university and college level back up to where it had been before this program starts. He does not want the Commission to reimburse them for prior cutbacks. The policy should be similar to the non-supplantation maintenance of effort in the way the grants are formed. Chair Steinberg reiterated that the money is not intended for direct services so the core that is being provided insufficiently at the campuses

is for direct services. Commissioner Dobson asked if this funding would be considered a part of the Proposition 98 funding. Chair Steinberg said it would not.

Commissioner Henry asked which MHSA funding would this funding for the initiative come from. Chair Steinberg said it will come for the State and Prevention and Early Intervention.

Commissioner Chesbro asked if there was any risk that any monies would go to backfill cut backs on mental health services that have occurred at colleges. Chair Steinberg said there is always a risk, but what he is asking for today is to approve the funding and have staff come back in July with the guidelines which will include the same sort of non-supplantation language that is in the other parts of the Act.

Commissioner Henning asked why there is a priority put on the college-age versus K-12. Chair Steinberg said he believes there ought to be more put into higher education because when PEI rolls out, K-12 will be a major part of the corpus of the prevention and early intervention funds, and he feels higher education has more of a potential to be left out. However, Ms. Mildred pointed out that if we are going to address the issues at universities and colleges we need to start earlier at K-12 so there is continuity. Commissioner Henning said that this is a great start, and as the programs are rolled out at the college level, he would also like to start looking at the technical schools and certified apprenticeship programs.

A Commissioner said this is a great initiative and a great start. His concern goes to the vast majority of people in the age range that do not go to college. At some point he would like to have an equivalent access point for the 2 out of 3 people who do not go to higher education.

Commissioner Gayle said he supports this initiative. The piece he is interested in is the LBGQTQ suicide rate, and being mindful of the trauma and bullying that this particular group of people go through in school and higher education. This initiative is needed, but he asked how it will be distributed in a culturally sensitive way. Ms. Mildred said the values of the MHSA need to follow these dollars and the mechanism for doing this is in the guidelines and the grant requirements. In the same way, data should be added about those who are the highest risk of suicide and should be given weight in the grant process.

VOTE ON THE MOTION: Motion carried unanimously.

MOTION: Commissioner Doyle moved to approve the formation of an OAC Public Mental Health Financing Technical Resource Group when adequate staff is available; seconded by Commissioner Lee. Motion carried unanimously.

MOTION: Commissioner Hayashi moved to initiate an Evaluation Coordination Committee as designed with the inclusion of an organization representing workers in the mental health field as a full member; seconded by Commissioner Henning.

Commissioner Henry asked how many committees the OAC has. Ms. Clancy said if this Committee is approved, there will be a total of 7.

Vote on the motion: Motion carried unanimously.

IV. Report on MHSA and Reduction of Disparities Information

Sergio Aguilar-Gaxiola, Director, Center for Reducing Health Disparities, UC Davis Medical Center provided the following report:

- This is an update of a project that was conducted in collaboration with the State Department of Mental Health for, and with, the underserved communities to address mental health needs.
 - There were approximately 250 participants from historically underserved communities across the state. He acknowledged Emily Nahat from the Department, Jennifer Clancy, Beverly Whitcomb, Rachel Guerrero, Nicole Davis for their help with this project.
 - “The most basic of all human needs is the need to understand and be understood. The best way to understand people is to listen to them.”
 - Reduction of disparities in mental health and access to mental health care is a central goal of MHSA, but how do we do this?
 - What are the problems that underserved communities experience and report?
 - How can mental health services better address the needs of underserved communities?
 - The group concentrated on the following four pieces of information as to where the disparities are:
 - Looked at groups who are historically underserved by mental health services
 - Looked at groups facing geographic or linguistic barriers of care
 - Looked at mental health priority populations
 - Looked at groups with high uninsurance, underinsurance and/or poverty rates
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 - A chart was shown with data that depicted Latinos, Pacific Islanders, and African Americans as being below other groups in terms of seeing a mental health professional in the last 12 months. The group with the lowest rates of service use is the Latino immigrants. This same group is among those who tend to have lower health insurance, have a very low income (below 200 percent of the Federal Poverty Level), and most do not have insurance that includes mental health coverage.
 - It is clear that in order to do this work, direct input is needed from underserved communities. This is not an easy task. Underserved communities may be:
 - Unaware of potential benefits
 - Not ready to participate in policy process
 - Suspicious and distrustful of mental health services
 - The Project goals are:
 - Conduct outreach to communities that have been underserved by public mental health services and not included in previous community stakeholder processes
 - Develop a community engagement process to ensure direct input from underserved communities based on: (a) respect and mutual trust; (b) investment in community relationships; and (c) collaborative action aimed at soliciting input regarding communities’ needs and perspectives
 - Solicit and gather input regarding Prevention and Early Intervention programs, priorities, and strategies
 - Principles of community engagement: community engagement processes are about personal and local relationships that should be:
 - Participatory
 - Cooperative
 - Conducive to learning from each other
 - Encourage community development and capacity building
 - Empowering communities
- It is also important to identify assets, strengths, resources within the communities.
- Outreach methods used were:
 - Identified specific underserved communities
 - Interviewed key informants to focus on specific needs within the communities

- Worked with “cultural brokers” or community health representatives to develop outreach strategies
- Conducted focus groups with community members about mental health needs, community assets, etc.
- Provided feedback to communities about the impact of the information collected on policy and services
- Preliminary Findings: Key themes from interviews and focus groups
 - Lack of housing
 - Exposure to trauma
 - Poverty
 - Social isolation
 - Linguistic barriers
 - Discrimination
 - Lack of access
 - Shame
 - Mistrust of the system
- The following is a quote from a participant regarding exposure to trauma: “I believe that the most important thing in this country is the living situation and daily life conditions. Things such as rent and bills create a massive and major depression. They cause many anxiety and depressive feelings.”
- The following is a quote from a participant regarding trauma: “If you make a little bit above, I don’t care how you get the money, you are so poor, that if you make a little above welfare you don’t get no assistance. None. You are shut down. You can’t get the help you need.”
- The following is a quote from a participant regarding social isolation: “Just like they say, no kids are left behind but yet here we are – left behind.”
- The following is a quote from a participant regarding discrimination: “All of a sudden they judge or treat a child different because of their family (if parents have tattoos). I feel that teachers that get placed in an environment like this – lower economic – they should teach them to help them and learn how to deal with people like us and not be so judgmental. To know that there is a lot of us that are striving to be better than where we are at. It is just that this is the card that we are dealt.”
- The following is a quote from a participant regarding lack of access: “It is a luxury. I myself have that belief that only someone with lots of resources, money or someone with lots of needs goes to a psychologist.”
- The following is a quote from a participant regarding shame: “As parents we blind ourselves to the fact that the child needs help and when we think of mental health services we say ‘my child is not crazy’. We don’t want our children to be crazy but we can look for help. In our culture we are afraid, shame that they say our child is crazy or prejudice.”
- Other preliminary findings:
 - Social networks and supports
 - Community based-grassroots organizations providing much needed services
 - Outreach workers
 - After-school activities
 - Family violence
 - Substance abuse
 - Emotional disorders in children
 - Parenting, parent-child interactions
 - Discrimination against persons with mental health issues
 - Social isolation, especially of elders

The following is a quote from a participant regarding family violence: “The established agency should go into the community. The community goes (to seek care) once the need is extreme. When domestic violence involves hitting.

Like in (name of agency) they don't treat you unless you show evidence of a hit.
The agencies should go into the community and be known by the community.

- Processes of community engagement
 - Mental health intervention projects emerging from these community collaborations
 - Requires time and open communication
 - Feedback to communities
 - Address ways to feedback information to counties
- Suggestions emerging from this process is to:
 - Engage underserved communities in places that matter to them (e.g., ESL classes, housing assistance, social service agencies)
 - Consider the role of paraprofessionals
 - Integrate mental health outreach and treatment with other health and social services
- Strengthening our community input process
 - Limited time or capacity to address all the communities in the state that have specific needs
 - How can we make community engagement an integral part of ongoing policy processes?
 - Outreach takes time and long-term investment in communication and building trust
 - How do we maintain relationships of trust with underserved communities over time?

Commission questions and comments:

Commissioner Doyle said a slide that he was surprised by was the one that showed the Native American community actually accessing services at a higher level than he would have guessed. He asked Dr. Aguilar-Gaxiola to say more about this. Dr. Aguilar-Gaxiola said the data is from the adult (18 and older) sample and is part of the California Health Interview Survey from 2005. At this point he cannot give his interpretation of the data until he has had a chance to analyze it.

Commissioner Chesbro asked if Dr. Aguilar-Gaxiola knew what the segment of the Native American population was, i.e., was it reservations or did it include urban Indian population. Dr. Aguilar-Gaxiola said he did not have the answer to this question now because he has not had a chance to qualify the data.

Commissioner Henning asked if it is known "urban versus rural", particularly in the Latino populations because there is a huge difference. Dr. Aguilar-Gaxiola said there are definitely differences in terms of access of care that the group has documented. Here in this data the distinction was made, but it would be important to control by several variables, i.e., if there are differences by geographic locations. He hopes to be doing this analysis in the near future.

Commissioner Lee asked what the study can give to the Commission that it can bite into. Dr. Aguilar-Gaxiola said without having had a chance to analyze all the data, especially the data that came from the focus groups, he cannot shed light about specific themes. These communities are dealing with basic needs and he cannot make sense of the data unless he looks at the totality of their situation. Commissioner Lee said he would be very interested in seeing the themes and the variability between different cultural and underserved groups, and how the themes either compliment or do not compliment one another.

Chair Steinberg said as transformation occurs over time, what will be specific short-term and medium-term strategies to do a better job of serving unserved and underserved communities. Dr. Aguilar-Gaxiola said the group has made some recommendations to the Department of Mental

Health that he is hoping will get into the guidelines and requirements for the counties. It is his hope, not only with this data, but also with other complimentary projects to be able to measure in terms of disparities statewide and by counties. Chair Steinberg asked Dr. Aguilar-Gaxiola to continue to bring back to the Commission specific strategies in order to help the Commission establish the short-term and medium-goals in addition to the transformation.

Commissioner Dobson asked for an explanation of the chart's last column, the LGBTQ. He said LGBTQ is an underserved community, but according to the chart they may not be. Bill Trippy (?) said he just started working on this one week ago and he did not prepare the background slides, but since some of the comments are statistical he provided some information. In smaller groups, such as the Native American and LGB, the data states is 50 percent plus or minus 3 points, meaning it could be 47 percent or 53 percent. There are levels of uncertainty because of the small samples. The members of the group are now building strategies to deal with these issues.

Commissioner Poat said the data concerns him because people would have to self-identify as having experienced psychological distress which would be a very subjective decision. This might be why there are such high numbers. He believes that it is important to get data base lines in order for the Commission to start their work. It is his hope that it gets down to two or three major policy choices as to where the Commission can start to address these problems. This is an excellent data-driven start to understanding what the choices are.

Vice Chair Gayle thanked Dr. Aguilar-Gaxiola for his presentation. He did caution that when he sees a presentation such as this, he needs more information regarding ethnicity. Specifics are important in order that Commissioners do not have to guess and/or ask questions that should be quite obvious. For instance, quotes that were being used should have been identified as to what ethnicity was speaking out.

V. Report from California Mental Health Directors Association: MHSA Information

Pat Ryan, Executive Director, CMHDA provided the following report:

- It is important for CMHDA scheduled on the agenda on a regular basis so the Commission can hear progress at the local level.
- The funding challenges of the community mental health system is a continuing reality at the local level and there are some very real challenges at the local level in counties continuing to provide their core services while they are also struggling to implement the various components of the MHSA and understanding what the rules are for implementing the components.
- The Association has been working with the State Department of Mental Health and with the Oversight Commission in developing guidelines and the rules and regulations.
- The community mental health system can only survive and thrive with a very healthy partnership between the State Department of Mental Health, the Oversight Commission and the community.
- One of the challenges at the local level has been unclear understandings about the roles and responsibilities of the Oversight Commission, the Department of Mental Health, and the counties.
- Counties are concerned about the continued delays in the development of the guidelines, getting them out and getting the community activated so they can decide what they want to work on and incorporate in their local plan.
- Rural counties have a particular challenge with the guidelines because many of the smaller counties are not getting enough money to make it work. She is hoping this is an area that everyone can work on before the guidelines come out as opposed to after.

- Counties are struggling with cash flow. The state owes counties back pay for AB3632 and EPSET claims payments totaling over \$700 million. This is a huge problem, in that some counties do not have money for payroll.
- It is not known whether AB2034 programs will be funded, and because of the supplantation provisions of the Act, counties are prohibited from using that money to supplant the current programs. They are struggling with what will be done with the people who are currently in the programs if this money goes away.

Chair Steinberg clarified that AB2034 is at risk but there is the possibility that the budget could be signed a couple days late. It is his hope that even with the uncertainty that the counties will not cut off the AB2034 clients on July 1 if there is not a budget in place. Ms. Ryan said that funding streams for county mental health have been threatened for several years and the Boards of Supervisors may not have the faith to continue AB2034 after July 1 if there is no budget.

- Counties are still excited and committed to transformation. Transformation is happening despite all the struggles. The sooner the money can be rolled out, particularly the prevention and early intervention, the sooner transformation will happen.

Questions and/or Comments from the Commissioners:

Commissioner Doyle said one of his concerns is that the MHSA states money can only be used for new clients, yet there are existing programs that have been whittled away by funding cuts over the last 10 years and people are not getting anywhere what they need in services. There are a fortunate few, who through the MHSA will get whatever they need. This may build a two-tiered system. He asked if there was concern about this among CMHDA. Ms. Ryan said counties are concerned about this as well. They believe in the full-service partnership approach to serving people, but unfortunately there is not enough money to serve all the people who need full service partnerships. There is a threat with having a Cadillac service for some and having not a lot left over on the other side. She is concerned about the public's expectations for being able to do everything for everybody. We need to be honest about what can be done and when.

Chair Steinberg asked if it is true that core mental health service, which many complain are insufficient, cheaper than what is trying to be accomplished through MHSA. And if it is not cheaper, what do we do to begin converting the core system to the full service partnership mode. Ms. Ryan said MHSA and AB2034 provide the flexibility to be able to provide whatever it takes and other funding streams do not provide this flexibility. It is all a matter of resources.

Commissioner Chesbro said a letter went out to the counties from the Commission expressing its concern about maintenance of effort at the county level. The Commission was told yesterday that Santa Clara County has added \$1,750,000 back to the Mental Health Budget to be sure that they would be at the level they were at in 2004. He asked if cuts will occur in other counties. Ms. Ryan said Santa Clara County has proposed the highest proportion of cuts of any county that she knows of, but there will be cuts based on the increase of cost of living and the revenues being flat.

Commissioner Doyle quoted what the Santa Clara County Account Executive said: "Although we are adamant in our position that maintenance of effort only applies to the state and not to the counties, nonetheless, we are adding back \$1,750,000 to make sure the county general fund level is at the same level it was in 2004 because we don't want to have this fight." It is his hope that the Commission can persuade all counties to maintain funding at least at the 2004 level.

Commissioner Diaz said she would like to hear from the director's themselves as to what options are out there for us.

Denise Hunt, Behavioral Health Director from Stanislaus County, said her county's CCS plan was approved in January 2006. She pointed out the following:

- MHSA funding for her county next year is only 8 percent of her department's budget. Because she runs a behavioral health department the programs include alcohol and drug, public guardian, and mental health services.
- Although MHSA is a significant part of what she does, she spends more of her time on 8 percent of the funding than she does on anything else.
- About the same time her county submitted their 3-year CSS plan she became aware that there were serious budget problems in the realignment funded mental health programs and client programs needed to be cut. Because of the flat realignment revenue, and because costs continue to go up, and the fund balance has been depleted services had to be decreased.
- When her plan was approved she found herself managing a budget process that had some significant reductions ahead, being in full scale implementation, and at the same time some community based programs had to be closed that were serving 400 people. Support staff had been depleted three years prior.
- Her county was doing their best and working long hard hours to get the requirements out and interpret the Act. The complexity of the interpretation of the Act and the complexity of the requirements have been very confusing and frustrating. The length of the approval process led to the 3 year plans being moved into 4 year plans. Timelines have slipped repeatedly. The process is onerous and there is a lack of confidence that the counties will ever see money that they are owed.
- There are all sorts of political pressures that hold sway as she is trying to transform the system.
- Funding components are organized in silos and separate in subject makes it very difficult to think in terms of an integrated plan into the future. We are trying to transform a dreadfully underfunded system that has gaps and disparities. It is challenging to try to think ahead and get programs up and do it all with not a lot of support or resource at the local level.
- It was good that the State was able to get the money out for the early implementation workforce education and training because her county had no resource left.
- The goal is not to develop two parallel systems, yet there are two parallel systems: a core system with people hundreds of people who are not getting enough; and then there is the MHSA programming. The goal is to pull everything along toward the same vision, but the counties do not yet have the tools and capabilities to do this.

Commissioner Lee said the counties are trying to operate with an unknown budget and if the OAC is to be active in trying to make transformation occur is then one of its roles to help the counties establish some sort of stable funding program outside of OAC's funds. Chair Steinberg said the Commission is on record opposing the 2034 cut and a lot of time is being spent advocating this issue.

Ms. Hunt said many of her county's full service partnerships are built on the foundation of 2034 and if this goes away, MHSA programming would lose a fair amount of its foundation and would have to be reduced. This is definitely an interplay. Chair Steinberg said 2034 has siloed funding. He asked if the existing core system and existing funding could be consolidated to create more full service partnerships that line up equal to MHSA, or perhaps, integrate the current funding into the MHSA. Ms. Hunt said the biggest challenge would be the few hundred people that the county would be hard-put to find other services for because of the restricted caseloads that are necessary. Chair Steinberg said we need to begin building the core services towards a full service partnership model, but how do we get there?

Commissioner Doyle asked if the Commission needs to address the barrier the requirement that a full service partnership and MHSA money can only go to new clients. Ms. Hunt said anytime you say who can and cannot receive a service a barrier is set up.

VI. Introduction to Prevention and Early Intervention

Ms. Clancy said she and Emily Nahat, Chief of Prevention and Early Intervention, Department of Mental Health will present the PEI draft guidelines. The presentation will be started with representatives from juvenile justice who will talk about their perspectives on the way in which the priority population related to youth in juvenile justice has been framed. Brian Lee, Deputy Director, Fight Crime: Invest in kids; Bob Ochs, Sonoma County Chief Probation Officer; and Sue Burrell, Staff Attorney at the Youth Law Center were introduced.

Brian Lee presented the following information:

- Youth in the juvenile justice system are included as a population that should be a priority for PEI funding. However, his concern is that the priority is limited to youth with signs of behavioral and emotional problems that have been identified at their first point of contact into the juvenile system.
- His recommendation is that youth in the juvenile justice system, regardless of when they are identified, should be a priority population. Therefore, he suggested taking out the words “first point of” in the language.
- In 2005 there were 220,000 juvenile arrests. More than half of those never go to juvenile court. Overall, 1 in 3 end up in a court finding. Most kids (84%) in the juvenile justice system remain at home. The average length of stay in juvenile hall is 23 days. The average length of stay in a county camp or ranch is 4 ½ months. So even the kids who are in custody at the county level will end up back at home relatively soon.
- Youth in the juvenile justice system is three more times likely to have a mental illness. In a survey, mental health issues are the single most critical gap in juvenile justice services and it is getting worse.
- The MHSA states that a goal of PEI is to reduce incarcerations. Delinquent behavior can be early manifestation of mental illness. The Community Services and Supports, which can also serve this population, is limited to those with severe mental illness.
- The problem with the current limitation of the first point of contact is that mental illness might not be diagnosed at first contact. Also mental illness might surface after the first contact. In addition, the first point of contact could have a disproportionate impact on youth of color.
- PEI funding will be used to directly benefit kids and not law enforcement.
- To the extent that this funding would go to kids in custody, the small minority of kids who are in the juvenile system, DMH has said this is okay as long as certain restrictions are met. The restrictions are: (1) you can not supplant existing funding; (2) the services must be voluntary, which is possible in an involuntary setting; and (3) it must be for the “purpose of helping the person get out of juvenile and live in the community”.

Chair Steinberg asked where it is clarified that the Department will opine custodial services. Mr. Lee said it is from “The Reader’s Guide to Mental Health Services Act Community Services and Support Three Year Program and Expenditure Plan Requirements.”

- Police Chief Cam Sanchez, President of the Police Chiefs Association, wrote “Juveniles should not lose out on access to needed services through no fault of their own, but just because law enforcement officials fail to identify their mental disorder

until after repeated contacts with the juvenile justice system.” So the first point of contact does not make since.

Bob Ochs, Chief Probation Officer from Sonoma County, member of Chief Probation Officers of California, and a licensed clinical social worker presented the following information:

- Probation Departments are not part of the State Department of Juvenile Justice. Probation is a county function with a Chief Probation Officer in each county. In juvenile justice the focus is on treatment and rehabilitation and the juvenile justice system has its roots in child welfare.
- The juvenile system is “child centered” and focuses on what is in the best interest of the child.
- The opportunity to prevent the development of a serious emotional disorder can present at any point during a child’s interaction with juvenile justice system.
- Youth who are appropriate for PEI services but are past the point of first contact should not be turned away simply because their problem has not otherwise been identified.
- In some cases kids go undiagnosed because their mental health problem has not yet emerged, and in other cases it is because their behavioral problems have not been attributed to a mental health condition. This is more likely to occur with youth of color.
- A child should not be penalized or denied help because the system is imperfect; the system will always be imperfect.
- County plans that include juvenile justice youth would allow probation departments to provide services through contracts with County Mental Health Departments and/or community based providers.
- There may be some misconception that this funding would somehow be co-opted and used to supplant existing law enforcement functions but this could not be further from the truth. Chief Probation Officers are not interested in this funding to bolster its law enforcement functions, but interested in it because this funding could help treat kids.
- Counties efforts to meet the stated goals of the MHSA are restricted by the current wording. If the current definition becomes permanent some counties may interpret it to mean that youth in the juvenile justice system past the first point of contact cannot be served with PEI funding. Therefore, kids who could benefit from early intervention would not be served simply because their needs were not identified in time. Allowing counties to include youth beyond the point of first contact with the system would result in a more comprehensive response.

Chair Steinberg said he feels the language that is being proposed is reasonable with two caveats: (1) MHSA will not fund custodial care; and (2) the Commission would request that its partners at CMHDA sit with the probation chiefs at the highest organizational levels to formulate a brief statement of joint recommendations on how to best serve the juvenile justice population.

Sue Burrell, Staff Attorney, Youth Law Center presented the following information:

- We all want to know how to make a difference in the lives of people who can be helped by MHSA.
- Broadening the definition of juvenile justice will make a difference in real peoples life because:
 - If you were to go in to any juvenile hall in this State you will see children who were turned in by group homes, by schools, by law enforcement, and by families because they did not know how to respond to misbehavior. The PEI funds can make a difference to those kids who are beyond the first door but are still in the early stages by getting them assessed, linking them with other funding streams, and focus on the family.

- This proposal will have a huge impact on children of color. It is appalling to see the disproportionate representation from arrest, detention, to representation to secure confinement of youth of color because kids of color are not being recognized and addressed before they get into the juvenile justice system. The underutilization of mental health services in the community leads many kids directly to the door of juvenile justice.
- By slightly broadening the priority populations to include kids past the first point of contact would go a long way and would have a real world impact on assuring that these young people get mental health services.

Commissioner Diaz said her concern is that the children living at home will not get the high need end because priorities are set for other populations, such as juvenile system and foster care.

Commissioner Gayle asked for the statistics of the foster youth in the criminal justice system as opposed to children living at home with their families. Ms. Burrell said there are statistics but she does not have them readily available. She did say that sometimes the children who are living with their families are the same kids who come into juvenile justice and are the same kids who go beyond the front door of juvenile justice. She just wants counties to have the option of designing their priorities.

Commissioner Hayashi asked about reducing recidivism. It is important to put money into mental health services but other issues should be addressed, such as education, work experience. She asked if a larger reform should occur at DJJ. Ms. Burrell said the action needs to occur at the county level; we need to keep kids from going into the system in the first place, which is one of the reasons that the PEI funding is so important; we also need to beef up the services that probation departments are able to provide to kids who do stay in the system.

Commissioner Doyle said the language was worded the way you see it is because of the concern that the criminal justice system can be a bottomless pit. California spends more money on jails and prisons than it does for public education. What he would like to see is an automatic, comprehensive mental health assessment of every kid at first point of contact in the juvenile justice system and the foster care system.

Commissioner Henry said if we are really going to deal with the juvenile justice problem and system in mental health, then it has to also help the children who are with their parents. Ms. Burrell said she does not want to focus on this population to the exclusion of prevention and serving children with their families, but don't close the door to these kids in the juvenile justice system.

Commissioner Lee said he has a basic objection to changing the language because if we don't force the issue of making the assessment at the first point of contact kids will continue to be unserved and into the system before they get something. If we are going to transform, then the Commission's role is to say, you do it when you first suspect anything so children don't get placed inadvertently in a system that could harm them dramatically.

Chair Steinberg said the language could say that the preference is the first point of contact but the county can opt to assist those in the juvenile justice system at any point. Commissioner Lee said then he would like to see evidence, at some point in the future, that the Commission's request is being responded to by the people in the field.

VII. Prevention and Early Intervention

- PEI Draft Guidelines: Presented jointly by Emily Nahat, Chief, DMH Prevention and Early Intervention Branch and Jennifer Clancy, Executive Director

- State-Administered Projects: The OAC approved some expenditures for state administered projects with agreement of the county mental health directors and DMH. The projects are:
 - ✓ Student Mental Health Initiative: OAC to provide \$4 million annually for four years
 - ✓ Stigma and Discrimination Reduction
 - ✓ Ethnically and Culturally Specific Programs and Interventions (a suggested starting point is that the first round of dollars be focused on Native Americans, Latinos, Pacific Asian Islanders, and African Americans)
 - ✓ Suicide Prevention: OAC approved \$14 million annually for four years plus up to \$50,000 million dollars per year for two years for a statewide strategic plan on suicide prevention.
 - The 42 member Suicide Committee will provide recommendations for DMH and Health and Human Services Agency's strategic plan on suicide prevention. OAC and stakeholders will have input before the Committee's final recommendations are made in spring of 2008.
 - The Committee will also provide input from the guidelines to the counties in order to provide effective, promising, and emerging practices that they can use as resource materials for doing their local suicide prevention activities.
 - Suicide Prevention on K-12, community college, CSU, and UC campuses
 - ✓ Training, Technical Assistance, and Capacity Building: Funding is \$12 million annually for four years
 - This will improve capacity of partners to assist in PEI
 - This is considered an incentive to counties to improve the strategies and prevention and early prevention key community needs
 - K-12, community college, CSU, and UC training to raise awareness of mental health issues and wellness
- Statewide Evaluation
 - Funding is up to 5 to 8 percent of the total county PEI funds. The PEI policies that the OAC acted on in January indicate the intent to use MHSA state administrative fund to fund this rather than local assistance funds.
 - DMH has developed a draft accountability and evaluation framework. The Department received feedback and met several times with OAC staff and commissioners, the Planning Council, CMHDA, and an advisory workgroup.
 - At the same time the Department has parallel activities to develop a draft MHSA accountability and evaluation framework. More staff discussion is to be scheduled before going forward with next steps.
- Ms. Clancy provided the following information:
 - After seeing the Preliminary (pre-release) Draft she was in agreement with the statewide project's design up to this point.
 - Recommendations from various discussions with Commissioners who have been involved with PEI is that the statewide evaluation funding should come from the Mental Health Services Act Administrative Funds.
 - Commitment to initiate the process by securing an external evaluator for the MHSA
 - Be involved in the staff discussion that would be organized by the Department, but continue to keep the focus on, as soon as possible moving towards an RFP process so that the external evaluation can begin.

- Ms. Nahat continued her presentation as follows:
 - Draft Proposed Guidelines
 - ✓ The Department provided a preliminary (pre-release) draft of the PEI proposed guidelines to the OAC and CMHDA for feedback. The following agreements on content and process were:
 - The emphasis shall be on user friendly and simple guidelines
 - The Department would operationalize the policies of the OAC in the guidelines
 - Get input from CMHDA on packaging and format and technical assistance content
 - OAC staff and DMH staff regularly communicate
 - OAC and DMH staff discuss any new policies and elevate to Commissioners and/or DMH leadership to resolve any questions.

- Ms. Clancy provided the following recommendations:
 - Emphasize user-friendly and simple plans
 - Figure out a way to get the money out within a timeline that makes sense and decrease the complexity
 - The Commission has to hold the principles of the Act and a key principle of the Act is to respect community-driven processes and the mental health system is transformed. So the guidelines have to have the ability to reflect a community-driven process which means there needs to be flexibility as well.
 - There is a significant interest for the accountability to be achieved through the demonstration of outcomes; individual level outcomes and societal level outcomes. The Commissioners wants to emphasize evaluation as a process to achieve accountability.

- Ms. Nahat continued her presentation as follows:
 - Draft Proposed Guidelines
 - ✓ The purpose of the requests for information in the counties' plans would be to:
 - Review and approve the program
 - Review and approve the proposed expenditures
 - Meet the State's fiduciary responsibility for expenditures and performance
 - ✓ The proposed contents of the counties' plan include:
 - Community Program Planning
 - PEI key community need(s) to be addressed
 - PEI priority population(s) to be served
 - Workplan(s)
 - Strategies
 - Budgets
 - Intended outcomes and measures
 - Coordination with other MHSA components
 - Certification on non-supplant

- Ms. Clancy provided the following recommendations:
 - Staff are in support of all the above mentioned proposed contents with the addition that the tone of the guidelines reflects intent language.

- Ms. Nahat continued her presentation as follows:
 - Community Program Planning and Infrastructure funding

- ✓ Proposed funding: Up to \$25 million statewide from the county planning estimates
- ✓ Purposes:
 - Outreach and engagement
 - Meetings, focus groups, public hearings, other communications activities
 - Data collection and analysis
 - Staff time and/or consultants
 - Staff development on PEI
 - PEI plan preparation
 - RFP development and other preparations for implementation
- Ms. Clancy provided the following comment:
 - Staff is supportive of the \$25 million because without dollars to be able to support the plan development, the plans would not be able to move forward.
- Ms. Nahat continued her presentation as follows:
 - Timeline
 - ✓ June/July: DMH develops preliminary draft proposed guidelines in collaboration with OAC staff and with input from CMHDA
 - ✓ July: Commissioners provide input to DMH on preliminary draft proposed guidelines. DMH makes edits needed and release the draft proposed guidelines in July
 - ✓ August: General stakeholder meetings to get input
 - ✓ September: Commissioners provide final input on draft proposed guidelines
 - ✓ October: DMH makes edits needed and releases final proposed guidelines to counties

Chair Steinberg asked where the public's input is pursuant to the OAH formal regulatory process. Ms. Nahat said the Department would be working parallel developing the Regulations, but it cannot be completed until everyone comes to agreement of what the guidelines should be. Chair Steinberg said his concern is that if the formal regulations are not completed when the county puts forth its application it will delay the distribution of the money. Ms. Hood said during the time that the counties are developing their plans, the regulation process will be completed so that by the time funds are ready to be released the regulations will be completed.

Chair Steinberg recommended taking the preliminary draft proposed guidelines in July, which will have been a product of much collaborative work, and put those out as the Regulations and use the stakeholder meetings and the formal process to solicit the input from the public on the proposed Regulations. Ms. Hood said the quickest way for the process is as proposed.

Chair Steinberg said with CSS, the Commission did not have to wait for formal regulation before the money was released. Ms. Hood said the regulations were in effect by the time the money was delivered and the entire process was started with the DMH letter, which is the same as proposed for PEI.

Commissioner Lee said that after CSS was released in draft, changes were made to the final. Ms. Hood said counties know that there is a risk when they use the draft guidelines.

Commissioner Doyle said the concern is creating an underground regulation before actual regulations come out. Ms. Hood said there is a risk and what she was trying to do is to balance this risk with moving things forward. She said what her strategy is, is to have prior to the money

actually going out, that there would be regulations in effect. The other alternative would slow this up substantially.

Commissioner Poat said his key message is, in order to keep things on track, is to stick to the July timeframe and everyone should bring their thoughts and comments to the July meeting, and unless it is a revolutionary thought, July is the time the Commission makes its decision.

Public Comment

Janet Paine, with Family Health Care Network, said she is also representing California Primary Care Association as the Chairman of the Mental Health Task Force. Her comments are directed to the draft MHSA PEI excerpts dated May 17, 2007. She supports the definition of the PEI as drafted because it aligns with an integrated primary behavioral healthcare model that many community health centers have incorporated into their health services. She also supports the Early Intervention definition that such services must be delivered in a setting that is not primarily designated mental health service delivery setting and where individuals have access to other services. She supports the PEI early intervention definition of providing mental health services that are short in duration and includes screenings for identification of mental health problems. She applauds DMH and OAC for specifically naming required sectors of recommended partner organizations, such as community health centers for inclusion in the PEI planning process.

Rose King, said she is a member of the public and political consultant and has an opinion about the stigma campaign. She believes someone should be hired to package all the recommendations into one coherent plan. She urged the Committee not to spend any money until it sees the plan and how the components fit together. She called attention to the basic discrimination that is in the Welfare and Institution Codes because it denies entitlement to mental health services. The goal of integrating primary care and mental health care cannot happen under the current Medicaid regulations. She suggested that the Department and counties provide a briefing to the Commission on this issue in order to get more focus on it. Ms. King asked the Commission if it can demonstrate that people with the first break who do seek services get them; can it demonstrate that these people get the necessary intervention and prevention services. If you cannot demonstrate this, than how can the Commission justify excluding them from the MHSA prevention programs?

A public member noted that Rose King is the mother of Proposition 63 and it was her idea to do an initiative on this back in the '80s and everything that has been done since was from her inspiration.

Sandra Marley, private client advocate and consumer said one of the things that she has not heard in regards to PEI is substance abuse. She believes this needs to be looked at because there is a need for prevention and education in this area. Education needs to be provided at the school level about how drugs can affect mental health. It would be good to work with some faith based organizations as well.

Andrew Phelps said sometime back he was Chair of the Berkeley Mental Health Board and he is now on the Leadership Committee for Santa Clara County Mental Health Services Act and there he represents San Jose City College. He said PEI has a lot to do with how one approaches the business of madness and the way people live it. He is working with a group in San Jose called the Coalition for Justice and Accountability, which is a multi-cultural police shootings group which is interested in getting more community advocacy to protect the community against the abuses of the police. There has to be advocates for the people out there in making them look sane instead of waiting until they get treated. Treatment is the wrong front-line process. Advocacy is the front-line process. The Berkeley Homeless Action Center, consists of lawyers, who provide advocacy to the homeless. The PEI should show very clear support for community advocacy that

will make it possible to improve the process of people taking responsibility first and then compassion for when they get stuck.

Nora O'Brien, from the California Department of Care Association, said eliminating disparities is very important, but the concern that she has is with the process to be used to allocate the funding and what will be the accountability measure for the release of these funds. She is recommending an advisory body when the OAC has the staff capacity. Make sure that we operationalize the funding criteria for PEI that was adopted last fall, as well as what was adopted in the government partners' agreement in January. Operationalizing all of the kinds of language that the Association put in, i.e., safeguard for community based organizations to be included in the planning process, as well as in the allocation process and building on existing community-based providers rather than creating new programs within the county. There is a need to be certain that the principles that are embedded within the policies (the committee that Commissioner Hayashi chaired) are operationalized when the Association sees the draft guidelines. She recognized the hard work of DMH and OAC to get to this process.

Michelle Vulgas (no card), said she is the Chief Counselor of MAS Social Services Foundation. MAS stands for Muslim American Society. She introduced Nefla Shifa to speak.

Nefla Shifa said the Muslim American Society Social Service Foundation is a new non-profit organization in Sacramento. The goal is to serve community members, in particular, Muslims who are seeking assistance in building strong healthy families. Initially there will be peer counseling offered in the area of parenting, marital, and teen issues. When the assistance needed is beyond the organization's current expertise, people will then be referred to licensed professionals and other agencies. Peer counseling can be offered in English, Arabic, and 13 other languages. In the future the organization will be working to reduce stigma surrounding seeking help for family and personal issues. Cultural competency training will be provided to mainstream providers. MAS will contribute to the new mental health model in a positive way by developing community support in a linguistically and culturally diverse state. She believes that MAS fits well with the prevention early intervention phase and she hopes this work will be planned in such a way to include her Muslim community.

Tina Mata, UACF Board member, said she supports Jennifer Clancy's report on the recommendations for the Prevention and Early Intervention on ethnic and cultural specific programs. She has a son who is Native American, Latino, and Bipolar. He has a difficult time obtaining services. She would like to see the PEI funding disbursed at the first mental health contact. She knows that the Juvenile Justice needs some funding but she is concerned that it would get lost somewhere and end up being the same old-same old.

Patty Gainer, a client from Sacramento, said she (1) likes the idea of going to the people and listen to what they know, build on what they have which is the strengths of the culture; (2) asked the Commission to go back and look at its records from the Modesto meeting. Sally Zinman provided a PowerPoint that was an "Ah Ha" moment for many people. The client led programs that are self-help and drop-in centers are very multi-cultural and they are reaching out to otherwise unserved people. They are very inexpensive and an alternative to the fail-first; (3) she is very concerned about the MHSA process at the local and state levels. She hears everyday about the serious grievances in the counties. Without having a process to investigate grievances and correct them they will continue to go unsolved. This is the Oversight and Accountability Commission and she asked that this Commission take responsibility to help establish a grievance process. During testimony and in writing the Commission said they would put this issue on the agenda and she is tired of waiting; (4) Regarding prevention and early intervention she asked that the Commission talk about real discrimination and things that can be measured, legislated, and enforced. There is a need is for more recovery based and have other options. The issues of neglect and trauma are not even considered.

Vice Chair Gayle said he acknowledged that Ms. Gainer had asked for a grievance process last year and the Technical Resource Group will take this up.

Delphine Brody said the California Network of Mental Health Clients is a statewide client-run organization and it is first and foremost concerned with what types of programs can be funded and will be the content of the recommended strategies that counties will see as a menu when the guidelines come out. These two particular issues have not been discussed as much recently in PEI and she would like to hear more about it. She would like to see a lot more attention paid to issues of transparency, particularly with regard to clients and family members accessing information from both the OAC and the DMH well in advance of key meetings where decisions will be made. She is disappointed with how things went in the fall and winter with key PEI votes taking place during major client conferences that prevented many from attending.

The Network has some questions, particularly around the community program planning and infrastructure. In terms of the various purposes when she hears outreach and engagement she would like to hear some explicit requirements that counties use some of this \$25 million towards scholarships and/or stipends for travel reimbursements for client and family members to bring them to local and state level meetings where PEI will be planned and implemented. She asked that the Commission please remember clients and family members and remember transparency.

Gwen Slattery, with Starview Community Services in Long Beach, California and also with United Advocates for Children and Families, said she is concerned about the new twist to the PEI because she had in mind that this money was going to go towards advertisements and provide awareness for services to those people underserved, etc. When she hears about some of this money going into juvenile justice it brings to mind the failed-first scenario again. The idea that juvenile justice will be working with PEI sends chills down her back because she fears there could be mis-use in minority communities. A much better expenditure for PEI funds is to make the community aware of where they can get services.

Chair Steinberg noted that on the stigma and discrimination reduction paper talked about yesterday, he does not see any inconsistencies from what Ms. Slattery is advocating. Part of the stigma effort is to get out the word that there are services available, where to access the services, why it is safe to access services, etc.

Darien Delu, from the Office of Co-Occurring Disorders with the Department of Alcohol and Drug Programs, said substance abuse is closely intertwined with many factors related to mental illness. She was glad to hear at least one other person bring up concerns around incorporating substance abuse, prevention and treatment into the MHSA PEI guidelines. She underscored some of the interconnections in terms of substance abuse and mental health: (1) substance abuse can contribute to and exacerbate mental illness problems so that substance abuse prevention programs and treatment programs deserve to be part of efforts directed to transition age youth as well as to adults; (2) substance abuse is frequently associated with violence. Violence has many destructive impacts that relate directly to mental illness. Through exposure to violence there is result in trauma, beyond that if we can offer substance abuse treatment to the parents in a violent home situation we can hope to reduce the violence and prevent the children from being thrown into the foster care system; (3) many expectant mothers are facing mental health issues connected with post-partum depression. Frequently, they are also the victims of domestic violence and they may be resorting to substance abuse so programs should be directed to expected and perinatal mothers, as well as families involved with Child Protective Services. She hopes that the guidelines will make more explicit references to both substance abuse prevention and treatment.

VIII. MHSOAC Recommendations for Prevention and Early Intervention

MOTION: Commissioner Doyle moved that the criteria be, in addition to CMHDA sit with the probation chiefs at the highest organizational levels to formulate a brief statement of joint recommendations on how to best serve the juvenile justice population, in addition the criteria will say “children and youth at risk of first or any contact with the juvenile justice system with signs of behavioral and emotional problems; seconded by Commissioner Dobson. Motion carried unanimously.

MOTION: Commissioner Hayashi moved that PEI initially focus on those racial, ethnic, and gender groups demonstrating historic disparities in access to mental health services; seconded by Commissioner that is unknown. Voice was not recognizable on tape.tstr

Commissioner Poat said this is the one area where he is sensitive to not include at this time gay, lesbian, transgender, and questioning youth. Commissioner Hayashi accepted the friendly motion to add in time gay, lesbian, transgender, and questioning youth. Motion carried unanimously.

MOTION: Commissioner Henry moved that the PEI timeline outlined today be approved with the exception of a final read by Commissioners in September in order to get the PEI funding to communities in a timely fashion the Commission will provide their final comments on draft guidelines in July 2007; seconded by Commissioner Poat. Motion carried unanimously.

Commissioner Henning said he does not remember an issue that the Commission has been faced where they have not contracted out. He has not seen any time spent making sure that the infrastructure for the Committee can be handled. He asked Ms. Clancy to provide a list of contracts as well as what they are for and the cost of each.

IX. MHSOAC Executive Director Search

Chair Steinberg provided the following recommendations: (1) the Commission hire an external executive firm to conduct the OAC Executive Director search; (2) initiate an Executive Director Search Committee to serve as a primary liaison with the external executive search firm; and (3) approve the Executive Director job announcement duty statement.

MOTION: Commissioner Hayashi moved the above recommendations; seconded by Commissioner Poat. Motion carried unanimously.

X. Adjournment

The meeting was adjourned at 3:00 p.m.

