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Highlighted colored comments are from the Community Partners as of 4/10/09 **FINAL DRAFT MEMORANDUM OF UNDERSTANDING 3/13/09**

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MEMORANDUM OF UNDERSTANDING BETWEEN THE Community Partners representing mental health stakeholder interests, DEPARTMENT OF MENTAL HEALTH (DMH), MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION (MHSOAC), CALIFORNIA MENTAL HEALTH PLANNING COUNCIL (CMHPC) AND THE CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION (CMHDA).

I. PURPOSE and GENERAL AGREEMENT

This Memorandum of Understanding (MOU) is an agreement entered into between community partners, DMH, MHSOAC, CMHPC and the CMHDA for the purpose of defining various roles and responsibilities and to improve the understanding and implementation of the provisions of the Mental Health Services Act (Act).

Where possible agreements codified in this MOU will be annotated to the relevant provisions of the MHSa. These will appear as citations in the body of the MOU. A copy of the MHSa is attached to this MOU as Appendix A.

All Parties to this MOU agree that the broader purpose served by this agreement is to form a successful partnership to achieve the stated mission of California's community based Mental Health System. The Parties also agree that the intent of the Act was to establish an enhanced continuum of care while expanding and transforming the existing community mental health system built upon the existing community mental health system, to transform community services to meet the systems of care set forth in statute and as amended by the act and to implement prevention and early intervention programs to transform the entry into services from a fail first system to a help first system. This means ending the current pattern whereby the referrals to the system come mostly from hospitals, law enforcement, homeless outreach, special education and child welfare, and increasing referrals to services from primary care and other forums for the early detection of mental health problems before they become disabling or life threatening. While there are clear prohibitions in the Act with regard to the expenditure of funds to supplant existing state or county funds, it is recognized that the intent of the Act cannot be achieved if the fundamental or core community mental health services are unavailable.

Reference:

Mhac//2009/090406rolesandresponsibilities

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Section 5891

With signature to this MOU the parties signify agreement with the provisions of this MOU.

The inclusion of the non governmental community partners in signing this MOU as representatives of many of the key stakeholder interests most directly impacted by decisions implementing the act is consistent with the intent of the act to ensure that county and state decisions reflect consumer family and other stakeholder input. It also signifies that while not legally responsible for any government decisions, these community partners acknowledge that they are also responsible for the success of the act and must be diligent and informed participants in state and local processes in order for the goals of the Act to be accomplished.

II. **BACKGROUND**

The agreements contained in this MOU are the result of a series of weekly-facilitated meetings attended by all Parties (Community stakeholder representatives were not asked to participate in this process) and held over a thirty- day period. The provisions of this MOU do not address questions of process and execution except where such discussion is necessary to clarify roles and responsibilities. The term “Plans” refers to the County Mental Health Plans that are submitted to the State for funding under the MHSA. The term Parties refers to the signatories to this agreement. The term “State entities” refers to DMH, MHSOAC and CMHPC. The term Act refers to the MHSA.

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III. **AGREEMENTS and UNDERSTANDINGS**

A. **STAKEHOLDER ENGAGEMENT AND PARTICIPATION**

1. **General Agreement:**

All Parties agree that while no specific definition of a “stakeholder process” is provided for in the Act, it is clear that the intent of the Act is to ensure that members of the larger mental health community have input into decisions and application of the Act’s provisions. It is the intention of the Parties to ensure that “direct//indirect stakeholder and community” input is considered in the program development, implementation and evaluation processes Community input should be considered in all aspects of the Act, including and especially given consideration by the OAC referenced in the Act. All Parties also agree that in all instances this input is advisory. This is weak language which allows the Parties to give “lip” service to considering input.

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It is recognized by all parties that input from underserved communities needs to be ensured.

While it is the intent of the act to establish mandatory processes to ensure that there is meaningful stakeholder input into all important decisions and that county plans must note differences and respond to any significant different recommendations, however, there is no requirement for obtaining consensus before provisions of the Act can be implemented. As used in this context, the term “stakeholders” refers to those who are directly and/or indirectly impacted by the programs and activities covered by the Act.

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Reference:

Section 4. Part 3.6 5840 (e) Section 10. Part 3.75845 (d);
5846 (c); 5848 (a) (b) (c)
Section 5. Article 11 5878.1 (a) Section 15 Part 4.5 5892 (c)

2. **Formulation of Regulations:**

To implement the provisions of the Act, DMH is required to draft adopt regulations. DMH has sole responsibility and authority for promulgating regulations pursuant to the Act. (The OAC provides policy basis for the regulations for PEI and Innovations. The regulatory process of the State provides for an accessible opportunity (ies) for stakeholders and other interested parties to provide comments which the DMH should seriously assess for substance and endeavor to incorporate into regulations prior to adoption of the regulations.

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3. **State vs. Local Stakeholder Involvement:**

MHSA provides for stakeholder involvement at both the State (DMH, MHSOAC & Planning Council and Local (County) levels. Counties need to ensure that representatives of racial, ethnic and other underserved communities have adequate input into the plans and are encouraged to do whatever it takes to accomplish this including additional meetings, separate meetings with targeted communities, and/or focus groups.

Counties through their Mental Health Boards and Commissions provide additional opportunities for local public input. This is not necessarily accurate. The quality of Boards and Commissions vary and the stakeholder process needs to be broader than participation before these bodies. Also, there are grave concerns about fear of retribution at these levels. Counties shall also meet standards for stakeholder participation established by regulation and shall seek to continuously ensure that there

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is meaningful input from stakeholders in making each significant decision.
This ensures that the Plans developed pursuant to the Act accurately have
the opportunity to reflect local need. The sentence deleted is not true in
many situations. Not known. Counties need to inform participating
stakeholders, in writing, of how their input was incorporated into a plan or
why it was not.

Title 9 Div. 1 Section 3300 of the CCR should be reviewed and referenced
here for more complete language regarding stakeholders. Reference:
WIC Section 5604 (a); 5604.2; 5604.3

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One of the primary purposes of The Act is, to enhance and improve how
serious mental illness and serious emotional disturbance is considered,
diagnosed and treated across the life span from children to older adults
including their families and loved ones. This section leaves out people
targeted in the Prevention and Early Intervention component who are “at
risk” of a serious mental illness or SED. It is the responsibility of the State
entities to ensure this occurs on a statewide basis, and a shared
responsibility of the 58 counties to ensure that this occurs in each county.
Therefore, each of the State entities (DMH, MHSOAC and the Planning
Council) shall are to seek stakeholder input using accessible modalities to
inform their decision-making.

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Should be “will” seek.

This stakeholder input must include input from representatives of racial,
ethnic, and other underserved communities.

There is no reason for this sentence.

~~The State entities acknowledge that in evaluating and acting upon input received from stakeholders, in the development of statewide criteria or strategies, they need to also consider the capacity of individual counties to plan for and implement what is being proposed, given the contractual relationship counties have with DMH.~~

4. Quality Improvement Process:

Stakeholders are important barometers with regard to the success of strategies implemented pursuant the Act. Creation of a feedback loop utilizing frequent Feedback at both the County and State level will contribute to the quality improvement in local mental health processes and potential documentation of best and promising practices. Doesn't say which entity is responsible for obtaining the feedback.

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How do state and local entities demonstrate that stakeholder feedback has been received and responded to?

No mention of culturally competent services and how these should be measured and improved.

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5. Funding For Stakeholders:

A portion of the planning funds “shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process.” The 5% administrative funds are to cover DMH, CMHPC and MHSOAC costs. “The administrative costs shall include funds to assist consumers and family members to ensure the appropriate State and County agencies give full consideration to concerns about quality, structure of service delivery or access to services”

County mental health programs are responsible for setting up a mechanism for stakeholders to access these funds. Needs to say where the stakeholder funding is included. It is not clear that the funds to assist consumers and family members are for planning also.

In cases where consumers and family members from racial and ethnic communities are not available to participate, representatives (who may also be providers) from these communities should be recruited and compensated as the consumer and family members.

Reference:
Section 15 Par. 4.5 5892 (c), (d)

B. DEVELOPING AND APPROVING PLANS

1. Determination of Priorities:

The Act and the systems of care referenced in the act set forth goals, objectives and priorities. Within that framework, all parties to this MOU including stakeholders at the state and local levels have different roles in helping to properly assess needs, shape priorities and add emphasis in the planning process. Stakeholders should have input into identifying priorities.

Reference:
Section 3. Purposes and Intent and Section 5840

2. Establish County Plan Requirements:

DMH establishes the requirements and criteria for the Plans based on priorities set forth in the Act and referenced sections of the systems of care and input from the other Parties to this MOU. Plan requirements are to be set forth in regulation.

Reference:
Section 5898
Section 5848 (c)

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Only the DMH has the authority to promulgate regulations for the implementation of the Act including Plan structure, priorities and criteria for funding. This responsibility to establish underlying criteria and principles is divided between DMH and OAC. after stakeholder input has been considered. This is a voluntarily agreement according to the spirit of ACT.The DMH annually informs Counties of the amount of funds available. The DMH evaluates the capacity of each county to provide for the planned services before approving a funding request.

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With regard to Prevention and Early Intervention as well as Innovation, MHSOAC has a unique role in approving plan expenditures for these elements before they can be funded. However, the development of the requirements for these elements of the Plans still falls within and is subject to the regulatory authority of DMH. The OAC should establish principles and direction for PEI and Innovation Plans

Reference:
Section 5848 (c)

The DMH has authority to increase the allocation for prevention and early intervention in any county when it determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the the proposed increase. MHSOAC has authority to increase the State allocation of funds for Prevention and Early Intervention programs if it “determines that all counties are receiving all necessary funds for services to severely mentally ill persons.”

Reference:
Section 5892 (a)

3. **Prepare County Plans:**

The Act requires the Counties to submit an initial 3-year Plan, which will be updated annually. All parties acknowledge that there may be future circumstances where consideration could be given to requiring Counties to submit new 3-year Plans based on lessons learned or reordering of priorities based on evaluation of outcomes.

The Act provides for an “integrated” Plan for Prevention, Innovation and System of Care Services. As the Act was initially implemented, Plans were submitted for different components of the Act. The Parties recognize that

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5. **Plan Implementation:**

The Act is clear that implementation of program elements is at the County level. DMH contracts with Counties to implement each element in accordance with the requirements of statute and regulations and the content of the approved plans for the purpose of achieving the desired outcomes set forth in statute and in the Plans.

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C. **IMPLEMENTATION, ACCOUNTABILITY AND EVALUATION**

1. **Accountability:**

Accountability to the public for ensuring “all funds are expended in the most cost effective manner and that services are provided in accordance with best practices” is the responsibility of all parties to this MOU. The DMH is responsible for ensuring that such criteria are reflected in regulations and in review of plans.

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Each County is accountable to its constituents and policy makers for the effective implementation of Plans and services contracted with DMH. Each County is accountable to the MHSOAC for the effective planning and implementation of the PEI and Innovation components of the ACT. Ultimately with regard to the Legislature and the general public all parties are accountable for the expenditure of funds and the outcomes resulting from these expenditures.

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2. **Oversight:**

MHSOAC is accountable for providing oversight over the performance of counties and DMH and making recommendations to DMH for changes in regulations and to the Governor and Legislature for additional actions whenever necessary to accomplish the goals of the Act. This oversight also includes but is not limited to providing an independent opinion as to the extent to which the goals and objectives of the Act are in fact being achieved. This role includes reviewing and providing comment on the allocation and use of funds covered by the Act. In terms of its oversight responsibility, MHSOAC has a stronger more defined role with regard to Prevention and Early Intervention as well as the Innovation elements provided for in the Act. e Parties agree that these oversight responsibilities require a systematic view of community mental health programs that may extend beyond the specific framework of the Act.

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3. **Evaluation of Outcomes and Best Practices:**

The Act and referenced systems of care call for evaluation of outcomes and results of implementation of Plans. One of the purposes of evaluating

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outcomes is to inform DMH if there is any need to adjust regulations and future plan requirements. [to better provide needed/requested services.](#) Another purpose is to inform the technical assistance and training efforts to ensure that the maximum benefit is received from the funded Plans.

Each County will [conduct frequent](#) rigorous evaluations of its community mental health programs as a part of the normal implementation of their Plans and through community based quality improvement programs. [Recipients of services and their families will be included as evaluators in these processes.](#)

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The CMHPC also has a role in reviewing and evaluating program performance for the entire community mental health system. It approves performance outcome measures and also has a role in establishing community services and support. [DMH or the Counties should be responsible for making results available to the public. It seems the results go to the DMH and then into a black hole.](#)

Reference:

Section 5772 (c)

Section 5848 (d)

MHSOAC also plays a key role in looking at [county by county and](#) overall state [performance and](#) trends and in evaluating the progress that is being made with regard to the enhancements to the community mental health system envisioned by the Act.

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[The MHSOAC will receive, review and compile all identified best and promising practices for sharing with all community mental health plans and community partners. In regards to evaluation and identification of best practices](#)-all Parties must collaborate and exchange information. What is to be avoided is a costly blizzard of duplicative reports and data mining. [How will this be done and who has primary responsibility?](#)

Reference:

Section 3 Intent and Purpose

Section 5840 (e)

Section 5821 (a)

Section 5845 (a) (d)

Section 5848 (a), (b)

Section 5772 (c)

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D. TECHNICAL ASSISTANCE AND TRAINING

The DMH has the primary role of providing education and training and technical support to Counties to develop professional and other occupational staff, and alternative (client and family member) staff necessary to support the successful implementation of the Plans developed pursuant to the provisions of the Act, provided however that all workforce education and training funds shall be expended in accordance with the five year education and training plan approved by the CMHPC.

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The CMHPC also serves in an advisory role to the DMH in other aspects of the development of its education and training policies and plans. , and technical assistance.

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The MHSOAC shall establish principles setting forth its policies to guide its decisions approving Prevention and Early Intervention and Innovation programs working with the other parties to this MOU.

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There needs to be more clarification regarding "joint state-county decision-making process" in regards to training and technical assistance.

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Reference:

- Section 8 Part 3.1
- Section 5820 (a-e)
- Section 5821 (a)
- Section 5822
- Section 5846 (a), (b)

IV. TERM

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This MOU shall be in effect for five years from its date of execution and will be reviewed at least biennially. From time to time Parties to this MOU may also agree to review the MOU based on the demonstration of changed circumstances with regard to either the provisions of the Act or conditions within the mental health community.

V. GENERAL PROVISIONS

A. This MOU may be amended at any time by written mutual consent of all Parties. All proposed amendments will be reviewed and commented on by stakeholders prior to going into effect. Any Amendments to this MOU will become effective on a designated date agreed to by all Parties.

B. This MOU is not in effect until signed by official representative of Parties.

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- C. Nothing contained in this MOU amends or changes the provisions of the Act.
- D. This MOU does not repeat language already contained in the Act unless required for clarification of the agreed upon provision.

Generally this MOU just restates what the parties are already responsible for and in too many instances leaves it to all the Parties with none of them clearly identified as having primary responsibility for see the task is performed.

General concerns:

OAC "oversight" is defined as "an independent opinion" How can we ensure that this opinion is truly independent?

This document marginalizes the oversight and accountability role of the OAC and gives it no actual authority.

This document is flawed in that, in its draft form, Community Stakeholders are not named as a Party to the MOU and have had no input to the process or content.

This documents represents a "minimalist" interpretation of the ACT and does not represent the "spirit" of the Act. This MOU will be reviewed 12 months after the document is initially approved by all Parties to reflect any needed changes or clarifications discovered in its first year of implementation.

Generally, this MOU "cherry-picks" parts of the MHSA and regulations that emphasize minimum adherence to the Act in those provisions.

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