- Programs for transition aged youth may have positive impacts of higher employment, less homelessness and fewer encounters with the legal system, and
- Parent-focused programs may result in improved parenting skills, family function and decreased depression, stress and anxiety.[126]

Still, its analysis also found that some counties lacked internal capacity or guidance needed to develop and meet their evaluation goals. Data on individual services also was inconsistent or unavailable across counties.[127]

Mission: Find Ways to Successfully Tell the Proposition 63 Story

Though the oversight commission and health care services department are planning ways to improve evaluation efforts through better data collection – an important undertaking in its own right – steps can be taken today to better demonstrate to voters, taxpayers, lawmakers and, importantly, mental health clients, families and advocates how the state is using this voter-approved investment.

Improving Transparency and Financial Accountability Online

To begin to address critics' concerns about where and how the MHSA dollars are spent, while also improving accountability to the public, lawmakers and others, the entities responsible for overseeing the act could better organize and consolidate existing financial information online. A model exists in the state's bond accountability website. After voters passed a series of bond measures in November 2006, Governor Schwarzenegger directed the Department of Finance to create a website for the public to readily access information on how the bond money would be used. Though not without its flaws,[128] the website – www.bondaccountability.ca.gov – includes overviews of the various programs and projects funded by the bonds as well as detailed information about expenditures including a project's name, description, objectives, amount of funding allocated, location and contact information. In particular, the website for Proposition 1B, transportation bonds, provides a range of information to accommodate those with only a broad interest to those seeking detailed information about where the funds were spent.

Building on this model, the state could use existing MHSA financial and program data to create a website that accounts for MHSA fund revenues and expenditures. At a minimum, the website should provide a fiscal

snapshot of both overall and current year revenues and allocations by program component areas, including information on the state's annual expenditures of the state administration funds. To help interested parties better understand where the money is spent, the site should allow users to see how much money counties receive by component area – and similarly, how much state agencies receive – and include a description of the funded programs with links to program websites. Among possible models is the example below:

Mental Health Services Act

How Much Revenue Has the MHSA Generated?
(dollars in millions)

Total Revenue Since 2004: $13.271 billion

* Estimated Revenue

Program Components	*Fiscal Year 2014-15*	
	Estimated Revenue (dollars in millions)	*Percent*
Community Services and Supports (CSS) Comprehensive mental health treatment for people of all ages with serious mental illness.	$1,254.6	72%
Prevention & Early Intervention (PEI) Programs to prevent mental illness from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system.	$313.7	18%
Innovation Funding for counties to design and test new and improved approaches to mental health service delivery with time-limited pilot projects.	$82.5	5%
Workforce Education and Training (WET) Programs to increase the number of qualified individuals to provide mental health services and improve the cultural and language competency of the mental health workforce.	N/A	N/A
Capital Facilities and Technological Needs (CFTN) Supports a wide range of county projects to support service delivery, including acquiring, constructing and renovating county-owned buildings or modernizing, updating and transforming clinical and information systems.	N/A	N/A

State Administration Supports administrative functions at the state level, including evaluation of the Mental Health Services Act.	$86.9	5%
Total All Components	**$1,737.7**	**100%**

Community Services and Supports

County	Current Fiscal Year Allocation
Alameda	$
Alpine	$
Amador	$
Butte	$
Calaveras	$

Alameda County Community Services and Supports

Program Name/Description	Component
Support Housing for Transition Age Youth Provides permanent supportive housing for youth who are homeless, aged out of foster care, leaving the justice system or residential treatment.	Full Service Partnership
Greater HOPE Adds housing, personal service coordination and medication capacity to existing mobile homeless outreach provider in South and East County.	Full Service Partnership
CHOICES for Community Living/Recovery Education Centers Integrates supportive housing, supportive employment, peer counseling and case management to enable clients to graduate from Service Teams system.	Full Service Partnership
Forensic Assertive Community Treatment Creates a multi-disciplinary community treatment team and community support center for adults with extensive criminal justice histories and those experiencing their first or second incarceration.	Full Service Partnership
Mental Health Court Specialist Team of mental health staff at Alameda courtrooms to provide assessment, treatment and advocacy for defendants with serious mental illness.	Outreach & Engagement / System Development

In addition to providing accessible financial and program information summaries, the state should maintain an easily-accessible online archive of MHSA plans and reports that it is required to receive from the counties, including three-year program and expenditure plans and annual updates and revenue and expenditure reports. Where possible, the archive should include other related documents, such as county cultural competence plans that describe how counties plan to address the cultural and linguistic needs of their diverse communities through their mental health system.[129] Improved accessibility to these types of reports would make it easier for consumers, families, advocates and stakeholders to compare programs across communities, research

successful practices, evaluate and measure how counties are addressing diverse cultural needs and reducing disparities, and effectively advocate for community needs.

Monitoring Progress Toward Statewide Mental Health Goals

Despite significant data limitations, the oversight commission has begun to evaluate Community Services and Supports and Prevention and Early Intervention programs – programs that together receive the lion's share of county MHSA funds. This work is both important and admirable. Yet, more can be done to help Californians better understand how this unique surtax has helped drive statewide progress toward the act's goals.

The oversight commission's website currently hosts a wealth of evaluation information. It describes its evaluation plans and priorities, houses an extensive body of reports and includes other documents. But this information is not organized in a way that makes it easy for an interested, but uninformed, Californian, to understand how the state is monitoring and evaluating progress towards the act's goals. Instead, individuals must cull through multiple and often lengthy reports.

The oversight commission could easily improve transparency by reorganizing information on its website, helping an interested individual better understand who has benefitted from MHSA-funded programs and how they have been helped. The oversight commission should begin by highlighting indicators already identified as important. For example:

- To begin to address the question of whom the act serves, the oversight commission should include, to the extent possible, data on its website detailing the number of individuals served, their ages, gender, racial and ethnic backgrounds and languages spoken.
- To address how the act had helped improve lives for those living with severe mental illness, the oversight commission could more visibly post information on key indicators – much of which is already available in the oversight commission's priority indicators trends reports.
- To better understand how prevention programs are working throughout California, the oversight commission could share data on the rates of negative statewide outcomes that result from untreated mental illness. The data would highlight rates of suicide, incarceration, school failure and dropping out of school. It also would show rates of unemployment, prolonged suffering, substance abuse, homelessness, removal of children from homes and recidivism rates among juvenile offenders.[130]

In sharing this information online, the oversight commission should replicate the approach it has taken in written reports that both analyze trends and clearly communicate any limitations with the data. Ideally, this level of transparency will allow interested Californians to better understand what the act has achieved, and also, help to identify where service gaps or challenges remain.

Building Infrastructure Necessary for Evaluation

The state must do a better job of answering critical questions about the act's achievements and evaluating programs to determine what really works. The state ultimately must also serve as the authoritative voice about what programs and services are effective in helping people get better and stay well. By disseminating proven practices in treatment and prevention, the state could be a resource to counties seeking to identify model programs and help ensure those types of programs are adopted statewide.

But the state can't play this role until it addresses the inadequacy of its mental health data system. Stakeholders told the Commission the system has reached the end of its usefulness despite significant investment of MHSA funds to prop it up. To analyze and evaluate MHSA-supported programs statewide, the state needs a data system that can deliver information from the local clinical level directly to the state, they said. Such a system would then allow the state to monitor outcomes for all mental health programs – from those serving the severely mentally ill to those trying to prevent mental illness from escalating – and compare results across counties.

As a first step to rectify this problem, the oversight commission voted in October 2014 to conduct a feasibility study assessing what mental health data is currently available within the Department of Health Care Services' behavioral health data systems. The study will likewise identify the oversight commission's current data and reporting needs and identify gaps between what it needs and resources available to get the data. A final report and blueprint estimating costs of improving state data systems is due to the commission in February 2015.[131]

While this is a step in the right direction and will likely provide important information about the state's data needs, it does not guarantee any next steps. The state then should take immediate action to ensure it is prepared to act on the findings of the study. The oversight commission and department should develop a formal plan and timeline to build and implement a comprehensive, statewide mental health data collection system capable of tracking data for all MHSA-funded programs, as well as the state's other behavioral and mental health programs.

Recognizing that building this type of data system may come at significant cost, the oversight commission and department should consider in their plan various funding options. One option in particular should be evaluated. The plan should consider using some of the act's state administration funds to build an appropriate data collection system. Use of those funds may easily be justified given the system's critical role in evaluating effectiveness of services provided through this act.

To ensure that progress is made in a timely manner, the oversight commission and department should also regularly report to the Legislature on their progress in developing this data system, as well as identify challenges that may arise.

Summary

Though the act appears successful in improving the range of mental health services provided in California, the state must now take steps to ensure that it can demonstrate those outcomes to voters, taxpayers, mental health advocates, patients and their families. As a start, the Mental Health Services Oversight and Accountability Commission must improve transparency about how much money the act generates each year and where and how it is spent. Further, the oversight commission must be able to better tell who has benefitted from the act and how. The commission's ability to tell this story will provide a basis for continued state support of these programs. It also will allow counties to adapt successful models to their communities. The state must act to overcome its technology infrastructure problem and create a mental health data system with improved data collection capacity. This system would help the oversight commission better evaluate and communicate the act's effectiveness, identify areas for further improvement and inform future policy decisions.

Recommendations

Recommendation 3: To make MHSA finances more transparent and make it easier for voters, taxpayers and mental health advocates, consumers and their families to see how and where the money is spent and who benefits from its services, the Mental Health Services Oversight and Accountability Commission should add to and update material on its website to include:

- MHSA revenues, by component and annual allocations, and the cumulative total revenue since voters approved the act.

- ❑ Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.
- ❑ Data to demonstrate statewide trends on key indicators such as rates of homelessness and suicide that show how well the act's programs help those living with mental illness to function independently and successfully.
- ❑ A rotating showcase of model programs in each of the component areas to clearly demonstrate examples of what works.
- ❑ All county MHSA plans and reports submitted to the state, including:
  - ✓ MHSA annual revenue and expenditure reports.
  - ✓ Three-year program and expenditure plans and annual updates.
  - ✓ Other relevant mental health reports, such county cultural competence plans that describe how a county intends to reduce mental health service disparities identified in racial, ethnic, cultural, linguistic and other unserved and underserved populations.

Recommendation 4: To promote meaningful accountability of the MHSA, the state needs access to reliable, timely information that allows it to monitor effective progress toward the act's goals. The Mental Health Services Oversight and Accountability Commission and Department of Health Care Services should:

- ❑ Immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system capable of incorporating data for all MHSA components, as well as other state behavioral and mental health programs.
  - ✓ This plan should address how the development of such a data collection system would be funded and should use a portion of the MHSA state administrative funds to support the effort.
- ❑ Regularly report to the Legislature on the progress made in developing this data system and identify challenges that arise.

Conclusion

Since voters passed Proposition 63 in November 2004, the Mental Health Services Act has survived serious challenges – from excessive bureaucracy that made distributing money to counties overly complicated to the Great Recession that brought deep cuts to the state's social service infrastructure. Through it all, state lawmakers played a key role in guiding implementation, an assignment typically not granted to the Legislature when voters pass ballot initiatives.

Stakeholders expressed to the Commission a strong sense of pride that the act has helped redefine how mental health services are provided in California, reorienting the system toward wellness, recovery and hope. While steering up to 80 percent of funding toward Californians with the most serious mental illnesses, an accompanying emphasis on innovative and preventative programs opened doors to new and experimental ways to reach people who might otherwise not seek help. These aspects of the act have been invaluable in expanding the range of mental health services for Californians. Stakeholders also expressed optimism for the future. The act has endured through its growing pains. Implementation is hitting its stride and settling in for the long run.

The state bureaucracy's current management arrangement, as ordered by the Legislature, is a step in the right direction, providing greater independence for the Mental Health Services Oversight and Accountability Commission and a new partnership in oversight with the Department in Healthcare Services. But in its review, the Commission found bureaucratic confusion remains and the oversight commission still lacks the authority envisioned to ensure that the annual $1 billion investment in the mental health system is achieving what voters intended. The Legislature must take the next step and grant the oversight commission the authority to review the more controversial prevention-oriented programs funded by the act before they are implemented, have a role in deciding how the state administrative portion of the funding is allocated and be empowered to impose sanctions if counties misspend funds from the act or fail to file timely reports with the state.

During the course of the review, many also shared frustration over the state's inability to address a significant long-running barrier. As described many times in this report, that is the technology challenge that

makes it hard, if not impossible, to demonstrate success or back up perceived outcomes with facts and data. Once again, the state is hampered by antiquated data systems. Overwhelmingly the Commission heard that more must be done, and soon, to build the infrastructure necessary for the state to effectively oversee and evaluate the impact of this significant investment. The Commission recommends that the oversight commission improve public access to the data and county plans that already exist and to do a better job of showcasing model programs. The oversight commission, working with Department of Healthcare Services, must immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system. The Legislature should consider using a portion of the Mental Health Services Act state administrative funds to pay for the data system.

Moving forward, communities and mental health advocates need to better understand how local programs are helping people recover. They need to know who might be falling through the cracks, and what other communities are doing to serve hard-to-reach populations. State lawmakers and local government leaders need better information to assess the state's progress in delivering mental health services and to identify shortcomings. But the audience is even broader: As California continues to experiment with mental health treatment programs, particularly for prevention and early intervention, its successes likely will inform how care is provided throughout the United States. Having data that ensures the best possible implementation will make the transformative effect of this act even more significant.

The Commission's review of Proposition 63 and its aftermath began with a simple question: Should the Legislature have more authority to tinker with successful ballot measures crafted often by special interests and sometimes carving out a revenue stream for their own purposes. This review offers unique insight into what happens long after voters say yes on election day. Proposition 63, in which a voting majority hiked income taxes for millionaires, can be described as extraordinary, establishing a powerful, continuing funding stream for mental health needs that usually fly well below the popular radar. We cannot know how implementation might have differed had the authors of this initiative not allowed for legislative involvement. But, in this case, the ability of lawmakers to amend the act, once implemented, appears to have allowed it to weather changes in the state's policy and fiscal environment while generally staying on course toward outcomes promised in 2004.

One final important question must address how much these successes might be due to the tone set by the leadership of the Legislature. To date, all significant amendments have been made under the watchful eye

of Senator Darrell Steinberg, Senate President Pro Tem from 2008 through 2014, and co-author of the Mental Health Services Act. Going forward, it will be beneficial to watch how the Legislature, under new leadership, uses its authority to guide implementation of the act. Though Proposition 63 alone would not make the case that allowing legislative amendments after an initiative passes should be routine, it does provide a case study that illustrates the potential for its benefits.

Additionally, the scope of this study purposely was limited to reviewing the oversight mechanisms for the Mental Health Services Act funds and the outcomes resulting from the state's historic investment in mental health services. However, revenue generated from the Mental Health Services Act only accounts for about 25 percent of the state's overall mental health funding. To better understand how the state manages and evaluates its broader mental health system, the state should consider reviewing governance among the various departments, councils and commissions involved in the system. Such a review might help the state consider whether opportunities exist to streamline oversight and reporting requirements for counties, improve coordination and leverage resources to best infuse the values of the Mental Health Services Act throughout the entire mental health system.

Appendices & Notes

- ✓ *Public Hearing Witnesses*
- ✓ *Timeline: The Shaping of California's Mental Health System*
- ✓ *Notes*

Appendix A

Public Hearing Witnesses

Public Hearing on the Mental Health Services Act
September 23, 2014
Sacramento, California

Karen Baylor, Deputy Executive Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Renay Bradley, Director of Research and Evaluation, Mental Health Services Oversight & Accountability Commission

Jessica Cruz, Executive Director, National Alliance on Mental Illness California

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition

Debbie Innes-Gomberg, District Chief, Mental Health Services Act Implementation and Outcomes Division, Los Angeles County Department of Mental Health

Michael Kennedy, Behavioral Health Division Director, Sonoma County Department of Health Services

David Pating, Vice Chair, Mental Health Services Oversight & Accountability Commission

Larry Poaster, Commissioner, Mental Health Services Oversight & Accountability Commission

Rusty Selix, Executive Director, California Council of Community Mental Health Agencies

Appendix B

Timeline: The Shaping of California's Mental Health System

1950's *– State operates eight hospitals serving 36,319 mental health clients (1956-57), but deinstitutionalization is becoming the predominant mental health public policy in the nation.*

1957 Short-Doyle Act: creates framework and funding for local governments to develop community-based mental health programs.

1960's *– Nurse Ratched, the sadistic nurse portrayed in the book and film "One Flew Over The Cuckoo's Nest," famously symbolizes institutional indifference to the mentally ill. California continues movement toward deinstitutionalization.*

1966 California establishes Medi-Cal program, with the State and Federal government sharing the costs of providing some mental health services.

1967 Lanterman-Petris-Short Act establishes standards and legal procedures for civil commitments to a mental hospital, ending the inappropriate, indefinite and involuntary commitment of mentally ill people. Also, increases state funding for community mental health programs.

1969 California begins closing three state hospitals.

1970's *– Deinstitutionalization is failing because financial support did not follow patients into the community. Governor Ronald Reagan vetoes legislation to move state funds to community programs, resulting in state's failure to distribute savings achieved through the closures of state hospitals to the community mental health system.*

1980's *– State allocations to counties to support community mental health are severely diminished due to inflation. Counties ability to fund mental health system is diminished further by passage of Proposition 13 in 1978. Homelessness and incarceration of mentally ill increases. Concerns rise about system's ability to meet needs of communities of color.*

1984 **AB 3622**, Special Education Pupils Program, requires schools to educate, mental health departments to treat, and social services to oversee placement of children with severe mental illness.

1987 **AB 377** expands pilot program to test the effectiveness of community- and home-based services for severely emotionally disturbed children.

1988 **AB 3777**, Wright, McCorquodale, Bronzan Act, moves California toward integrated and community-based "system of care" for adult mental health clients. Bill authorizes funding for three pilot projects in Ventura, Los Angeles and Stanislaus Counties as alternative to state hospitalization.

1989 The state begins reducing its General Fund commitment to mental health services. Because these services are not established as "entitlements," it is difficult for them to compete for state General Fund dollars through times of economic recession and diminishing state revenues.

1990's *– The California Mental Health Planning Council reports that California's mental health system is inadequate financially and suffers from a lack of clear governance structure. While the state controls the funding and the counties are responsible for providing services and operating programs, neither is fully accountable.*

1990 State projects a $14 billion General Fund shortfall and leaders look to cut various programs, including those pertaining to mental health. **AB 904** mandates the California Planning Council to create a Mental Health Master Plan.

1991 **AB 1288**, the Bronzan-McCorquodale Act, or Realignment I, uses funds raised by an increase in the state sales tax and vehicle license fee to shift fiscal and administrative responsibility for many mental health services from the state to counties, institutionalizes the "systems of care" service delivery model consisting of consumer- and family-focused services, personal service plans, coordinated care, intensive case management assistance and measureable and accountable delivery of services.

1995 California moves to implement Medi-Cal Mental Health Managed Care. Each county establishes a single Mental Health Plan for providing Medi-Cal services.

1999 **AB 34** provides funding for three pilot programs to provide integrated services to the homeless. Proves successful in lowering hospitalization, incarceration and homelessness.

2000's *– California voters approve landmark initiative to invest in mental health services, including preventive and new and innovative models of care. The Great Recession lessens impact of new funds.*

2000 Little Hoover Commission issues *Being There: Making a Commitment to Mental Health*, and calls for a transformation of the state's mental health system.

AB 2034 expands the 1999 AB 34 pilot program to more than 30 counties.

2001 Little Hoover Commission issues *Young Hearts & Minds: Making a Commitment to Children's Mental Health*, and calls for a redesign and integration of services provided to mentally ill children.

2002 **AB 1421**, Laura's Law, allows counties to provide court-ordered outpatient treatment or anti-psychotics for people with serious mental illness.

2004 **53.8 percent of voters approve Proposition 63, the Mental Health Services Act.**

2005 Proposition 63 implementation begins January 1; establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) within the Department of Mental Health to oversee MHSA programs.

2009 **AB 5xxx** separates the MHSOAC from the Department of Mental Health and requires it to issue guidelines for INN and PEI component programs and speeds state approval for county mental health program plans.

2010's *– Amid federal health care reform, Legislature shifts more oversight responsibility for the Mental Health Services Act to the counties.*

2010 The federal Patient Protection and Affordable Care Act requires health insurance plans offered through new health insurance exchanges to provide a minimum package of essential health benefits, including mental health and substance use disorder services.

2011 **AB 100**, aiming to speed funds to counties, significantly reduces the state's role in administering the MHSA. Eliminates state reviews of county mental health plans, requiring MHSOAC only to provide training and technical assistance for county mental health planning. Transfers administrative responsibilities of MHSA funds from the Department of Mental Health to the State Controller and reduces the cap of state administrative funds from 5 to 3.5 percent.

The 2011-12 budget includes a one-time use of $861 million MHSA funds, most of which is used to support realignment of fiscal responsibility for two Medicaid programs: mental health managed care, including inpatient and psychiatric and outpatient services primarily for adults, and early and periodic screening, diagnosis and treatment (EPSDT), a federally mandated program requiring a broad range of screening, diagnosis and medically necessary treatment services to Medi-Cal beneficiaries under age 21.

2012 **AB 1467**, part of a package of bills to eliminate the Department of Mental Health, transfers responsibility for administering MHSA to Department of Health Care Services beginning July 1, 2012. Also expands the MHSOAC's role of providing evaluations, training and technical assistance. Requires counties to provide the commission with three-year program and expenditure plans and annual updates, but does not specify what the commission must do with these plans.

SB 1009 completes reorganization of mental health services out of the Department of Mental Health effective July 1, 2012.

2013 **SB 82**, the Investment in Mental Health Wellness Act, aims to improve access to mental health crisis services. Uses a portion of MHSA state administration funds to expand crisis beds and mobile crisis capacity.

AB 82 requires the MHSOAC to work with DHCS and others to design a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system.

Sources: Eli Lilly and Company. 2008 Navigating the Currents: A Guide to California's Public Mental Health System. p.6 Report produced for the California Association of Local Mental Health Boards and Commissions. Also, Diane Van Maren, Consultant, Senate Committee on Budget and Fiscal Review. Overview of the 2000-01 Budget Bill: California's Mental Health System- Underfunded from the Start. Also, Secretary of State. Approval Percentages of Initiatives Voted Into Law. www.sos.ca.gov/elections/ballot-measures/pdf/approval-percentages-initiatives.pdf. Also, Mental Health America of California. Overview of the 2000-01 Budget Bill, California's Mental Health System – Underfunded from the Start. www.mhac.org/pdf/mh_funding.pdf. Also, California State Auditor. August 2013. Mental Health Services Act. Report 2012-122.

Notes

1. California Secretary of State. 2014. "History of California Initiatives: Summary of Data." Accessed November 13, 2014. http://www.sos.ca.gov/elections/ballot-measures/pdf/summary-data.pdf.
2. Note: In recent years, California's voters have passed two initiatives to increase taxes: Proposition 63 (2004) and Proposition 30 (2012).
3. California Secretary of State. November 2, 2004, Presidential General Election. Statewide Ballot Measures. Pages 7-9. Accessed October 17, 2014. http://www.sos.ca.gov/elections/prior-elections/statewide-election-results/presidential-general-election-november-2-2004/statement-vote/.
4. Note: The Little Hoover Commission supported AB 1422 based on its November 2000 report, "Being There: Making a Commitment to Mental Health."

   Source: AB 1422 (Thomson, 2001). April 16, 2001. Assembly Committee Bill Analysis.
5. Diane Van Maren, consultant, Senate Committee on Budget and Fiscal Review. Overview of the 2000-01 Budget Bill: California's Mental Health System-Underfunded from the Start.
6. AB 1422 (Thomson, 2001) was vetoed by Governor on 9/30/02. http://leginfo.legislature.ca.gov.
7. Howard Padwa, UCLA Health Services Research Center. Rusty Selix Interview. Pages 24-25. Accessed on October 17, 2014. http://www.mhac.org/pdf/rusty-selix-interview.pdf.
8. Rusty Selix, executive director and legislative advocate, California Council of Community Mental Health Agencies. September 23, 2014. Testimony to the Commission.
9. Mental Health Services Act, Section 18. Accessed December 12, 2014. http://www.mhsoac.ca.gov/docs/MHSA_AsAmendedIn2012_AB1467AndOthers_010813.pdf.
10. Rusty Selix. See endnote 8.
11. Initiative & Referendum Institute. "Comparison of Statewide Initiative Processes." University of Southern California. Page 26. Accessed on May 5, 2014. http://www.iandrinstitute.org/New%20IRI%20Website%20Info/Drop%20Down%20Boxes/Requirements/A%20Comparison%20of%20Statewide%20I&R%20Processes.pdf. Also, Jason Sisney, Deputy Legislative Analyst, State and Local Finance, California Legislative Analyst's Office. May 6, 2014. Phone Interview with Commission staff.
12. ABX3-5 (Evans), Chapter 20, Statutes of 2009-10 Third Extraordinary Session. Also, Assembly Bill 100 (Committee on Budget), Chapter 5, Statutes of 2011. Also, Assembly Bill 1467 (Committee on Budget), Chapter 23, Statutes of 2012. Also, Assembly Bill 82 (Committee on Budget), Chapter 23 of 2013.
13. Larry Poaster, commissioner, Mental Health Services Oversight and Accountability Commission. September 23, 2014. Written testimony to the Commission. Also, Rusty Selix, executive director and legislative advocate, California Council of Community Mental Health Agencies. August 1, 2014. Personal communication with Commission staff. Also, Michael Kennedy, behavioral health division

director, Sonoma County Department of Health Services. August 27, 2014. Personal communication with Commission staff.

14. California HealthCare Foundation. July 2013. Mental Health Care in California: Painting a Picture.

15. Legislative Analyst's Office. July 2004. Proposition 63: Mental Health Services Expansion and Funding. Tax on Incomes Over $1 Million. Initiative Statute. Accessed on October 22, 2014. http://www.lao.ca.gov/ballot/2004/63_11_2004.htm.

16. Rusty Selix. See endnote 8.

17. The California Budget Project. September 2004. Budget Brief: What Would Proposition 63, the Mental Health Services Act, Mean for California? Page 4. Accessed on October 22, 2014. http://www.cbp.org/pdfs/2004/0409prop63.pdf.

18. Lynda Gledhill. "Campaign 2004 – Prop. 63 calls on rich to fund mental health." October 22, 2004. San Francisco Chronicle.

19. Evan Halper. "State's Voters Agreeable to New Tax – on Millionaires." October 12, 2004. The Los Angeles Times.

20. Tamara Koehler. "Ballot measure would raise money for mental healthcare." October 22, 2004. Ventura County Star.

21. Mental Health Services Act. Section 3. Purpose and Intent.

22. Mental Health Services Act. Welfare and Institutions Code, Section 5813.5. Also, California Department of Mental Health. 2009 MHSA expenditure report to legislature. Page 2. Accessed on October 24, 2014. http://www.dhcs.ca.gov/services/MH/Documents/08_09AddendumMHSA_LegReport.pdf. Also, California Department of Health Care Services. May 2014. Mental Health Services Act Expenditure Report. Fiscal year 2014-15. Pages 3, 7. Also, Debbie Innes-Gomberg, district chief, MHSA implementation and outcomes division, Los Angeles County Department of Mental Health. September 23, 2014. Testimony to the Commission.

23. Mental Health Services Act. Welfare and Institutions Code, Section 5840. Also, California Department of Health Care Services. Mental Health Services Act Expenditure Report. March 2014. Fiscal year 2014-15. Pages 12-13. Also, California Department of Mental Health. See endnote 22. Page 2.

24. California Department of Health Care Services. See endnote 22. Pages 3, 14.

25. Mental Health Services Act. Welfare and Institutions Code, Section 5830. Also, California Department of Mental Health. See endnote 22. Page 2.

26. California Department of Health Care Services. See endnote 22. Pages 3, 16.

27. Mental Health Services Act. Welfare and Institutions Code, Section 5892. Also, California State Auditor. August 2013. Report 2012-122. Pages 9-10.

28. Mental Health Services Act. Welfare and Institutions Code, Section 5822. Also, California State Auditor. See endnote 27. Pages 9-10.

29. California Department of Mental Health. See endnote 22. Page 2.

30. California Department of Health Care Services. August 7, 2013. MHSD Information Notice No.: 13-15. Page 2.

31. Karen Baylor, deputy director, mental health and substance use disorder services, California Department of Health Care Services. September 23, 2014. Written testimony to the Commission. Page 2.

32. Mental Health Services Act. Welfare and Institutions Code, Section 5892(d).

33. California Department of Health Care Services. See endnote 22. Page 3.

34. Personal Communication from Carla Castaneda, principal program budget analyst, Department of Finance. August 13, 2014. Mental Health Services Fund (MHSF-3085), Accrued Revenue, 2014-15 May Revision.

35. Personal Communication from Carla Castaneda. See endnote 34.

36. Jessica Cruz, executive director, National Alliance on Mental Illness California California. September 2014. Written testimony to the Commission.

37. Note: During the five year period between fiscal years 2011-11 and 2014-15, the California public mental health system received 42% from state sources including the general fund, state sales taxes and the state vehicle license fee; 32% of funds from federal sources; 24% from the Mental Health Services Act and 3% from various other sources at the county level – such as local property taxes, patient fees and insurance and grants. LHC staff calculation.

    Source: Larry Poaster, commissioner, Mental Health Services Oversight and Accountability Commission. September 23, 2014. Testimony to the Commission. Also, Mental Health Services Oversight and Accountability Commission, Financial Oversight Committee Financial Oversight Report. May 22, 2014. Included with written testimony to the Commission, September 2014.

38. Debbie Inness-Gomberg, district chief, MHSA implementation and outcomes division, Los Angeles County Department of Mental Health. September 2, 2014. Written testimony to the Commission.

39. Jessica Cruz. See endnote 36.

40. Larry Poaster. See endnote 13.

41. Larry Poaster. See endnote 13.

42. Michael Kennedy. See endnote 13.

43. Debbie Inness-Gomberg. See endnote 38.

44. WIC Section 5655.

45. Department of Finance. June 3, 2008. Final Report – California Department of Mental Health, Mental Health Services Act Performance Audit.

46. David Pating, vice chair, Mental Health Services Oversight and Accountability Commission. September 23, 2014. Written testimony to the Commission.

47. Department of Finance. See endnote 45.

48. David Pating. See endnote 46. Also, personal communication with Commission staff. August 29, 2014.

49. Department of Finance. See endnote 45.

50. Department of Finance. See endnote 45.

51. Department of Finance. See endnote 45.

52. Sherri Gauger, interim executive director, Mental Health Services Oversight and Accountability Commission. September 23, 2014. Written testimony to the Commission.

53. ABX3-5 (Evans). See endnote 12. Also, Senate Rules Committee, Office of Senate Floor Analyses. February 14, 2009. Also, Sherri Gauger. See endnote 52.

54. California Department of Health Care Services. August 7, 2013. MHSD Information Notice No: 13-15. "MHSA: Methodology for Distributions to Local Mental Health Services Fund." Also, AB 100 (Committee on Budget). See endnote 12. Also, Senate Rules Committee, Office of Senate Floor Analyses. March 17, 2011, Senate Floor Analysis.

55. Karen Baylor. See endnote 31.

56. Assembly Bill 1467 (Committee on Budget). See endnote 12.

57. Assembly Bill 82 (Committee on Budget). See endnote 12. Welfare and Institutions Code Section 5846. Also, Sherri Gauger, interim executive director, Mental Health Services Oversight and Accountability Commission. December 9, 2014. Personal communication with Commission staff.

58. Karen Baylor. See endnote 31.

59. Rusty Selix, executive director and legislative advocate, California Council of Community Mental Health Agencies. September 23, 2014. Written testimony to the Commission.

60. Jessica Cruz, executive director, National Alliance on Mental Illness California California. September 23, 2014. Testimony to the Commission.

61. California Department of Health Care Services. 2014. Accessed November 21, 2014. http://www.dhcs.ca.gov/services/MH/Pages/MHPCRolesResponsibilities.aspx and http://dhcs.ca.gov/services/MH/Pages/MHCouncilMembers.aspx. Also, Mental Health Services Act Expenditure Report. Fiscal year 2014-15. Page 22. Also, AB 1467 (Committee on Budget). See endnote 12. Also, California Department of Public Health. 2015. http://www.cdph.ca.gov/programs/Pages/OHEAboutUs.aspx. Also, David Pating. See endnote 46. Also, Sherri Gauger. See endnote 52. Also, Karen Baylor. See endnote 31. Also, California Department of Health Care Services. See endnote 22.

62. Michael Kennedy. See endnote 13. Also, Karen Baylor. See endnote 31.

63. Rusty Selix. See endnote 59.

64. Michael Kennedy. See endnote 13. Also, Stacie Hiramoto, director, Racial and Ethnic Mental Health Disparities Coalition. August 15, 2014. Personal communication. Also, Jessica Cruz, executive director, NAMI California. August 25, 2014. Personal communication with Commission staff. Also, Jim Gilmer, public comment at September 23, 2014 Little Hoover Commission hearing.

65. Stacie Hiramoto, director, Racial and Ethnic Mental Health Disparities Coalition. September 23, 2014. Written testimony to the Commission.

66. Jessica Cruz. See endnote 36.

67. Jessica Cruz. See endnote 36.

68. Rusty Selix. See endnote 59.

69. Hannah Dreier. July 29, 2012. "Calif mental health dollars bypassing mentally ill." The Associated Press.

70. Rusty Selix. See endnote 59.

71. Sherri Gauger, interim executive director, Mental Health Services Oversight and Accountability Commission. December 9, 2014. Personal communication with Commission staff.

72. Sherri Gauger. See endnote 52.

73. Sherri Gauger. See endnote 71.

74. WIC, Section 5847.

75. Mental Health Services Oversight and Accountability Commission executive staff. October 28, 2014. Personal communication with Commission staff.

76. Welfare and Institutions Code, Section 5845 (d)(10).

77. Karen Baylor. See endnote 31. Also, December 11, 2014. Personal communication.

78. Melissa Roland, Legislative Coordinator, Department of Health Care Services. December 30, 2014. Personal communication.

79. Assembly Bill 1467 (Committee on Budget). See endnote 12. Also, Welfare and Institutions Code, Section 5899.

80. California Code of Regulations, Title 9, § 3510.

81. Filomena Yeroshek, chief counsel, mental health services oversight and accountability commission. December 10, 2014. Personal communication. Also, Donna Ures, program outcomes, evaluation, and reporting section chief, mental health services division, California Department of Health Care Services. December 11, 2014. Personal communication.

82. Donna Ures. See endnote 81.

83. Jessica Cruz. See endnote 60. Also, Stacie Hiramoto, director, Racial and Ethnic Mental Health Disparities Coalition.. September 23, 2014. Testimony to the Commission.

84. Jessica Cruz. See endnote 60.

85. The WayBack Machine Internet Archive. Captured January 21, 2012, http://www.dmh.ca.gov/Prop_63/MHSA/State_Interagency_Partners.asp.

86. Department of Finance Health and Human Services program staff. August 13, 2014 and November 7, 2014. Personal communication with Commission staff.

87. California Department of Health Care Services. See endnote 23.

88. California Department of Health Care Services. Mental Health Services Act Expenditure Report. Fiscal year 2014-15. Also, Carla Castaneda and Teresa Calvert, Department of Finance. August 13, 2014. Personal communication. Sacramento, CA.

89. Larry Poaster. See endnote 13.

90. Darrell Steinberg, California Senate President pro Tempore. September 14, 2014. Personal communication with Commission staff.

91. Note: As of October 2014, the Proposition 63 website, prop63.org, maintained by the Mental Health Services Oversight and Accountability Commission, stated that "more than $8 billion dollars has been generated since Proposition 63 went into effect in 2005." Total revenues for each year are not available on the website. The California Department of Health Care Services website provides a similarly incomplete fiscal picture.

    Sources: Mental Health Services Oversight & Accountability Commission. 2015. Mental Health Services Act. "Proposition 63 Today." http://www.prop63.org/about/prop-63-today/. Also, California Department of

Health Care Services. 2014. "MHSA Funding." http://www.dhcs.ca.gov/services/MH/Pages/MHSAFunding.aspx.

92. Donna Ures. See endnote 81.

93. The Department of Health Care Services. MHSA Fiscal References. Accessed December 22, 2014. http://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx. Also, The Mental Health Services Oversight and Accountability Commission website. Accessed on December 22, 2014. www.mhsoac.ca.gov.

94. Karen Baylor, deputy director, and Brenda Grealish, chief of the mental health services division, California Department of Health Care Services. September 23, 2014. Testimony to the Commission.

95. Department of Mental Health. "Component Allocations and Approved Amounts." Accessed December 22, 2014 at http://www.dhcs.ca.gov/services/MH/Documents/ApprovedAllocations.xls

96. National Alliance on Mental Illness, California. September 2013. "MHSA Programs 2013: Saving Lives, Saving Money." Pages i, vi. http://www.namica.org/announcements/eng/mhsa%20full%20report%20final.pdf.

97. Mental Health Services Oversight and Accountability Commission. Prop. 63 MHSOAC Evaluation Fact Sheet: Assessing California's Mental Health Needs. Accessed November 18, 2014. http://mhsoac.ca.gov/Evaluations/docs/FactSheet_Eval1_AssessingCAMHNeeds_Dec2012.pdf.

98. Mental Health Services Oversight and Accountability Commission. See endnote 97.

99. David Pating. See endnote 46. Also, Sherri Gauger. See endnote 52.

100. Mental Health Services Oversight and Accountability Commission. Prop. 63 MHSOAC Evaluation Fact Sheet: Summary and Synthesis of County MHSA Evaluations. Accessed November 18, 2014. http://www.mhsoac.ca.gov/Meetings/PriorMeetings_2013/docs/Meetings/2013/OAC_032813_Corr_SummAndSynthOfMHSAEvalFactSheet.pdf.

101. Mental Health Services Oversight and Accountability Commission. UCLA Statewide Evaluation of MHSA – Priority Indicators Trends. July 24, 2014. Accessed November 18, 2014. http://www.mhsoac.ca.gov/Meetings/PriorMeetings_2014/docs/Meetings/2014/July/OAC_072414_Handout_4A_UCLAStatewide_EvaluationOfMHSA_PPT.pdf.

102. Pasha Mikalson, project director with Mental Health America of Northern California. September 23, 2014. Public comment to the Commission.

103. Janet King, community relations coordinator, Native American Health Center. September 23, 2014. Public comment to the Commission.

104. Nicelma J. King, Ph.D., cooperative extension specialist, UC Davis Department of Human and Community Development and project director, African American Strategic Plan Workgroup. September 24, 2014. Letter to the Commission.

105. Stacie Hiramoto. See endnote 83.

106. Mental Health Services Oversight and Accountability Commission. October 23, 2014. Commission Meeting.

http://www.mhsoac.ca.gov/Meetings/PriorMeetings_2014/docs/Meetings/2014/October/Commission/Motions%20Summary%20Oct%202014.pdf.

107. Joan Meisel. March 25, 2013. "Mental Health Services Oversight and Accountability Commission Evaluation Master Plan – Final." http://mhsoac.ca.gov/Evaluations/docs/EvaluationMasterPlan_Final_040413.pdf Also, Mental Health Services Oversight and Accountability Commission. 2014. "Evaluations." http://mhsoac.ca.gov/Evaluations/.
108. Sherri Gauger. See endnote 52.
109. David Pating. See endnote 46.
110. Rusty Selix. See endnote 59.
111. Karen Baylor. See endnote 94.
112. Sherri Gauger. See endnote 52.
113. Richard Van Horn, chair, Mental Health Services Oversight and Accountability Commission. September 23, 2014. Testimony to the Commission.
114. Mental Health Services Oversight and Accountability Commission. See endnote 101. Also, Sherri Gauger. See endnote 52.
115. Debbie Innes-Gomberg. See endnote 38.
116. David Pating. See endnote 46.
117. Mental Health Services Oversight and Accountability Commission. See endnote 101.
118. UCLA Center for Healthier Children, Families & Communities. May 20, 2014. California's Mental Health Services Act – Statewide Evaluation. Priority Indicators Trends Report – Executive Summary (Deliverable 2.G.2). Accessed November 25, 2014. http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_4A_PriorityIndicatorsTrendsReport_UCLA.pdf.
119. Mental Health Services Oversight and Accountability Commission. Evaluation Fact Sheet #6. Priority Indicators. Accessed on November 20, 2014. http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/FactSheet_Eval6_PriorityIndicators_2014_JAN.pdf. Also, Mental Health Services Oversight and Accountability Commission. See endnote 101. Also, MHSA. Highlights from MHSOAC Evaluation Activities: July 2014. Accessed on November 20, 2014. http://www.mhsoac.ca.gov/Evaluations/docs/FactSheet_HighlightsFromMHSOACEvaluationActivities_July2014.pdf.
120. Mental Health Services Oversight and Accountability Commission. Evaluation Fact Sheet #6. See endnote 119. Also, MHSOAC. California's Mental Health Services Act – Statewide Evaluation. "Priority Indicators Trends Report." Interpretation Paper. July 2014. Accessed on November 24, 2014. http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_Handout_4A_TrendsReport_InterpretationPaper.pdf.
121. Mental Health Services Act. Welfare and Institutions Code, Section 5840(d) (PEI).
122. Rusty Selix. See endnote 59.
123. Mental Health Services Oversight and Accountability Commission. Evaluation Fact Sheet. Summary and Synthesis of County MHSA Evaluations. Also, Sherri Gauger. See endnote 52.
124. Filomena Yeroshek. See endnote 81.

125. Sherri Gauger. See endnote 52.

126. Mental Health Services Oversight and Accountability Commission. See endnote 100. Also, MHSA. Highlights from MHSOAC Evaluation Activities: July 2014. See endnote 119.

127. Mental Health Services Oversight and Accountability Commission. See endnote 100.

128. Little Hoover Commission. June 2009. Bond Spending: Expanding and Enhancing Oversight. Report #197. http://www.lhc.ca.gov/studies/197/report197.html.

129. California Department of Mental Health. March 15, 2011. "California Department of Mental Health Cultural Competence Plan Requirements." http://www.dhcs.ca.gov/services/MH/Documents/CCPR10-17Enclosure1.pdf. Also, California Department of Health Care Services. 2014. "Cultural Competence." http://www.dhcs.ca.gov/services/mh/pages/culturalcompetenceplanrequirements.aspx.

130. Mental Health Services Act. Welfare and Institutions Code, Section 5851(c)(3) (CSS for children), Section 5801(b) (CSS for adults) and Section 5840(d) (PEI).

131. MHSOAC. October 23, 2014. Commission Meeting. Agenda Item 3A: Consider Recommendation for a contract to develop a feasibility study report or advanced planning document to evaluate the Department of Health Care Services behavioral health data systems. See: http://www.mhsoac.ca.gov/Meetings/PriorMeetings_2014/docs/Meetings/2014/October/Commission/Motions%20Summary%20Oct%202014.pdf. Also, http://mhsoac.ca.gov/Meetings/docs/Meetings/2014/October/Commission/OAC_102314_FINAL3A_Summary.pdf

Little Hoover Commission Members

Chairman Pedro Nava *(D-Santa Barbara)* Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Advisor to telecommunications industry on environmental and regulatory issues and to nonprofit organizations. Former state Assemblymember. Former civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

Vice Chairman Loren Kaye *(R-Sacramento)* Appointed to the Commission in March 2006 and reappointed in December 2010 by Governor Arnold Schwarzenegger. President of the California Foundation for Commerce and Education. Former partner at KP Public Affairs. Served in senior policy positions for Governors Pete Wilson and George Deukmejian, including cabinet secretary to the Governor and undersecretary for the California Trade and Commerce Agency.

Assemblymember Katcho Achadjian *(R-San Luis Obispo)* Appointed to the Commission by Speaker of the Assembly John Pérez in July 2011. Elected in November 2010 to the 33rd Assembly District and re-elected to the 35th District in November 2012 and 2014. Represents Arroyo Grande, Atascadero, Grover Beach, Guadalupe, Lompoc, Morro Bay, Paso Robles, Pismo Beach, San Luis Obispo, Santa Maria and surrounding areas.

David Beier *(D-San Francisco)* Appointed to the Commission by Governor Edmund G. Brown, Jr. in June 2014. Managing director of Bay City Capital. Former senior officer of Genetech and Amgen. Former counsel to the U.S. House of Representatives Committee on the Judiciary. Serves on the board of directors for the Constitution Project.

Senator Anthony Cannella *(R-Ceres)* Appointed to the Commission by the Senate Rules Committee in January 2014. Elected in November 2010 an re-elected in 2014 to the 12th Senate District. Represents Merced and San Benito counties and a portion of Fresno, Madera, Monterey and Stanislaus counties.

Jack Flanigan *(R-Granite Bay)* Appointed to the Commission by Governor Edmund G. Brown, Jr. in April 2012. A member of the Flanigan Law Firm. Co-founded California Strategies, a public affairs consulting firm, in 1997.

Don Perata *(D-Orinda)* Appointed to the Commission in February 2014 and reappointed in January 2015 by the Senate Rules Committee. Political consultant. Former president pro tempore of the state Senate, from 2004 to 2008. Former Assemblymember, Alameda County supervisor and high school teacher.

Assemblymember Anthony Rendon *(D-Lynwood)* Appointed to the Commission by Speaker of the Assembly John Pérez in February 2013. Elected in November 2012 and re-elected in 2014 to represent the 63rd Assembly District. Represents Bell, Cudahy, Hawaiian Gardens, Lakewood, Lynwood, Maywood, Paramount and South Gate and the North Long Beach community.

Senator Richard Roth *(D-Riverside)* Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to the 31st Senate District, representing Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris and Riverside.

David A. Schwarz *(R-Beverly Hills)* Appointed to the Commission in October 2007 and reappointed in December 2010 by Governor Arnold Schwarzenegger. Partner in the Los Angeles office of Irell & Manella LLP and a member of the firm's litigation workgroup. Former U.S. delegate to the United Nations Human Rights Commission.

Jonathan Shapiro *(D-Beverly Hills)* Appointed to the Commission in April 2010 and reappointed in January 2014 by the Senate Rules Committee. Writer and producer for FX, HBO and Warner Brothers. Of counsel to Kirkland & Ellis. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

Sumi Sousa *(D-San Francisco)* Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Officer of policy development for San Francisco Health Plan. Former advisor to Speaker Pérez. Former executive director of the California Health Facilities Financing Authority.

Full biographies available on the Commission's website at www.lhc.ca.gov.

"Democracy itself is a process of change, and satisfaction and complacency are enemies of good government."

Governor Edmund G. "Pat" Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California

VII.

MHSA Assessment & Recommendations Committee Report

CMMC MAC Committee Call AGENDA
Friday, January 16, 2015
1:30 pm – 3:00 pm
Dial: 1 (800) 410-3590 – Passcode: 7201208
Facilitator: Erin

Attendance: Poshi Mikalson, Beatrice Lee, Emma Oshagan, Michelle Alcedo

Not in attendance: Gulshan Yusufzai, Jamila Guerrero-Cantor,

Staff: Erin Reynoso

1:30 pm **Roll Call**

1:35 pm **Review & Approve** December 19th Minutes

1. No changes to minutes

1:40 pm **State of the State V Update**

- Key Informant Interviews
- Next Steps
- Description for Women

1. We have finished 4 KI interviews
    a. Still trying to connect with Dr. Flores (Jamila's-contact on Woman and Viviana-Older adults)
    b. Emma- Contacting the older KI and forwarding them to Katherine
    c. The due date is asking for full approval in June. And hopefully having a DRAFT by March.
    d. Next step is data analysis-
        i. Assigning themes or commonalities
        ii. We have looked into having the Emerging Leaders help with data analysis
            1. Poshi/Emma- It might be above the ELs expertise and for continuity sake we should keep with what we have done in the past
    e. Discussed names on Stipend list
        i. Action item: Emma will ask the past Armenian KIs whether they would like to receive the stipend
    f. Description of woman-

i. Discussion on the definition
ii. Action item: Send to committee one more time in order to give members one more time to discuss the definition.
iii. Action Item: Poshi- Should we send it to Christina and Mari for their expertise and insight?

2:10 pm **Dissemination Plan**

- Review Dissemination Ideas Document & Tracking Document
- Webinar Series

a) State of the State reports have been posted on the REMHDCO website
b) Webinar series
    a. Approval will need to come from CMMC
    b. Many of the avenues will be easy but some might be more strenuous
    c. Webinar could give each report a time in limelight
    d. Email will probably be the best distribution method
    e. A "launch" type thing might be an ideal strategy for dissemination
c) Press conference at end of process
d) Committee leaning towards a panel discussion that would include representatives from every community discussed in the reports
e) Action item: We will present our decision on State of the State dissemination in March
f) Action item: Before the next call the committee members should look into some ideas for how to disseminate the reports
g) Can we create a one-page synopsis/executive summary for each report
    a. Present easily digestible form of larger reports for distribution at meetings or conferences
    b. Poshi- An infographic with live links might be another option
        i. Action item: Poshi will send the link to Erin
    c.

2:40 pm **Special Report: PEI Regulations**

a. This topic has been approved by the CMMC and staff

2:50 pm **Announcements & Upcoming Meetings**

- Next MAC Call: February 20, 2015
- Next OAC Meeting: January 22, 2015
- Save the Date! Next CMMC Meeting: March 25th (tentative)

a. If you have a problem with this date please tell Michael ASAP

- Upcoming CRDP Strategic Plan Town Hall Meetings – *Please note they are asking for attendees to register in advance*

3:00 pm Adjourn

CMMC MAC Committee Call AGENDA
Friday, February 6, 2015
1:30 pm – 3:00 pm
Dial: 1 (800) 410-3590 – Passcode: 7201208
Facilitator: Gulshan

Attendance: Gulshan Yusufzai, Poshi Mikalson, Jamila Guerrero-Cantor, Katherine Elliott, Emma Oshagan, Michelle Alcedo

Not in attendance: Christina Quinonez

Staff: Erin Reynoso

1:30 pm **Roll Call**

1:35 pm **Review & Approve** January 16th Minutes

1:40 pm **State of the State V Update**

1. Key Informant Interviews
    a) Completed all KI Interviews but one
    b) Dr. Evette Flores scheduled for Monday, February 9
    c) Katherine concerned with a lack of diversity in interviews
        - Michelle: Could we look back into the SPW reports?'
            - We could acknowledge them as a literature review, although the reports might not cover the same questions that we asked during our interviews
        - Katherine's opinion is to find two more KIs that have an expertise that stretches among more categories
            - One for Native American and one for African American
            - Viviana had another potential KI candidate
        - Also, use past reports to gather additional information
        - Jamila: I will interview Dolores further this weekend.
        - Decision: Katherine will move forward with an interview for Native American and African American with an emphasis for people that have background in older adults and women
        - Poshi recommended Michi Fu for API population
            - Emma offered to contact and interview Michi
        - Erin will contact Nicki King

- Jamila will interview Janet King

d) Data analysis
   - Would it be appropriate for the ELs to assist with DA?
     - MAC committee feel it would be a great opportunity for the ELs
     - Contact Mari to facilitate a collaboration with the EL committee regarding data analysis

2:10 pm **Dissemination Plan**

- State of the State Panel Presentation
- Documents: Dissemination Ideas Document & Tracking Document
  a) Option 1-Panel discussion
     - One in Sacramento
       - Set up in conjunction with the CMMC in-person meeting or other conferences
     - One in Southern California
  b) Option 2- Half day panel
     - Two panels- one after the other
     - Two hours for each panel
  c) Webinar is another possibility
  d) Committee chose 1 half day conference
     - Erin will create an agenda or draft for 1 half-day conference

2:50 pm **Announcements & Upcoming Meetings**

- Gulshan would like to move the call in order to attend her prayer services
  a) Erin will send some options and send them to the committee
- Next MAC Call: March 20, 2015
- Next OAC Meeting: February 26, 2015
- Save the Date! Next CMMC Meeting: March 25th (tentative)
- Remaining CRDP Strategic Plan Town Hall Meetings – *Please note they are asking for attendees to register in advance*

3:00 pm Adjourn

CMMC MAC Committee Call AGENDA
Friday, December 19th
1:30 pm – 2:30 pm
Dial: 1 (800) 410-3590 – Passcode: 7201208
Facilitator: Michelle

Attendance: Poshi Mikalson, Jamila Guerrero-Cantor, Emma Oshagan, Katherine Elliott, Beatrice Lee, Michelle Alcedo
Not in attendance: Christina Quinonez
Staff: Michael Helmick, Erin Reynoso

1:30 pm **Roll Call**

1:35 pm **Review & Approve November 21st minutes**

1. Poshi provided an overview of the last OAC meeting
   a. Next OAC meeting is January 22nd
   b. It was great that the CMMC was able to submit a letter regarding racve and ethnicity as well.
2.

1:40 pm **State of the State V: Self-Identified Women Lead**

1. Decided the lead for "Self-Identified women" would be Erin
   a. No volunteers from the CMMC
   b. Most key informants have already been identified
   c. CMMC recommended MAC committee should interview a trans woman for the report
   d. Should we interview subject matter experts or people with lived experiences?
      i. Traditionally it has been subject matter experts
      ii. It is easier to interview experts because scope is limited and we don't have the resources to do a full RIB protection of our interviewees
      iii. It would be nice to have some overlap of expert/transwoman but in the alternative it would be most useful for our needs to interview matter experts
2. Action item: Erin will contact Mari to set an interview and Michelle and Katherine will conduct the interview.
3. Poshi: Kate is unavailable as an interviewee

a. Jamila- Yvette Flores –A woman from UC Davis (Chicano/Chicana studies) who is an expert in issues of psychology
    i. Very knowledgeable to issues of gender identity
    ii. Action item: Jamila will contact her after the new year, give her background on the project, and follow up with Erin regarding who will conduct the interview
4. Action item: Erin, along with Poshi, will try to set up a new interview with Faith

1:45 pm **Additional key informant for Self-Identified Women**

a. CMMC would like us to consider adding a transwoman or someone who represents transwomen
    i. Christina Quinonez
    ii. Mari Radzik

2:05 pm **"Self-Identified Women" Title & Description**

a. Concerns with the term "self-identified women"
b. DRAFT Description for the report:

For the purpose of this report, the term self-identified women is intended to include transgender/trans women, cisgender women and others who identify themselves within the spectrum of the gender identity of woman.

This language is used to intentionally expand the traditional definition of woman to include individuals whose gender identity may be incongruent with some (or all) of the aspects of gender that are assigned to their biological sex; our physical appearance and our genitalia are not the only determinants of gender.*

**gender identity: internal, deeply felt psychological identification as a man, woman or some other gender, which may or may not correspond to the sex assigned to them at birth.*

1. CMMC felt the term "self-identified women" is confusing
2. We should definitely add a definition of what we mean by our term, specifically
3. Let's put "Creating a catchy overall title"
4. Action Item: Send Poshi the previous State of the State reports
5. Action item: Poshi- Can we replace the "/" in the definition to a comma
6. Action item: Everyone send their preferences for title to Erin one week prior to next MAC call (January 9th)
7. We have decided to go with "Women"- With a descriptive clarification of the definition
8.

2:25 pm **Announcements**

Next MAC Call: January 16, 2015

Next OAC Meeting: January 22, 2015

2:30 pm **Adjourn**

CMMC MHSA Assessment Committee
Report for the CMMC In-Person Meeting
March 25, 2015

Members of the Committee:
Michelle Alcedo, Co-Chair, Gulshan Yusufzai, Co-Chair, Jamila Guerrero-Cantor, Beatrice Lee, Poshi Mikalson, Emma Oshagan, Christina Quinonez

State of the State Update

MAC has been making good progress on the State of the State Report and has completed eleven total key informant interviews with the final interview scheduled to take place on March 26th for a total of twelve key informants (five key informants for each community and two key informants that covered both communities).

This year's report is focused on women and transition age & older adults from underserved racial, ethnic, and cultural communities.

Over the next month or so, Katherine will be working with interested Emerging Leaders to begin the data analysis process. After that concludes we will begin drafting the introduction and background sections.

State of the State Report Dissemination Update

The committee has created a list of dissemination ideas and would like to start moving forward with them.

State of the State Email Blast

The first item they would like approval for is a graphic to email out to partnering organizations highlighting the four reports currently on the REMHDCO website. This graphic would be included in an email as a way to make said email more eye catching and interesting. The email will link directly to the State of the State reports at http://remhdco.org/cmmc/reports/.

The MAC would ask that other CMMC members either share their contact lists with us or commit to forwarding the email blast once it is sent so that the report can be disseminated broadly.

State of the State Poster Presentation

Jamila Guerrero-Cantor submitted an abstract for a poster presentation on the Deaf and Hard of Hearing Report at the upcoming American Deafness and Rehabilitation Association conference and it was accepted. Jamila is already planning to attend the conference (at no cost to REMHDCO/CMMC) and will be able to present on the poster.

If CMMC members know of any other conference/poster opportunities they are encouraged to share these with MAC.

State of the State Panel Presentation

One idea the MAC would like to move forward on is planning and executing a State of the State Panel presentation. This presentation would be modeled after the World Café and would take place after the completion of the fifth report and would highlight all the reports. The World Café approach would allow for a more interactive, interpersonal experience which will encourage dialog and maximize understand of the communities in each report.

While a date has not been picked yet, the committee would like to piggy-back on another event or conference to help ensure a better turn out. Media may also be invited to the event.

MAC would like the CMMC's approval to move forward with the planning process as well as suggestions for possible events we may piggy-back on.

Related Documents: List of Dissemination Ideas, Draft State of the State email blast graphic, Draft State of the State Panel Presentation Agenda

Addressing Mental Health Disparities:
A presentation on the five State of the State Reports

2015

10:00 am – 3:00 pm

Time	Agenda Item	Who	Notes
10:00 am 15 min	Welcome & Introduction	CMMC Member	Welcome & introduction of panel participants and overview of the CMMC and the State of the State Reports. Explain the format of the day
10:15 am 45 min	Presentation 1: Penetration Rates	Katherine? Who should present on these findings?	Presenter will present on findings of this report. Consider: • Overview of what penetration rates are and what they mean. • Cover top level information for each community in the report. • Recommendations as identified in the report
11:00 am 45 min	Presentation 2: Armenian Community & Deaf & Hard of Hearing Community	Key informant from report? MAC member from community?	• Who we are • Our history • Challenges as identified in the report • Success as identified in the report • Recommendations as identified in the report
11:45 am 45 min	Presentation 3: Russian Speaking, Middle Eastern, and Southwest Asian Communities	Key informant from report? MAC member from community?	• Who we are • Our history • Challenges as identified in the report • Success as identified in the report • Recommendations as identified in the report
12:30 pm 30 min	Lunch on your own (?)		
1:00 pm 45 min	Presentation 4: Refugee/Asylees &	Key informant from report? MAC member	• Who we are • Our history

Addressing Mental Health Disparities:
A presentation on the five State of the State Reports

2015

10:00 am – 3:00 pm

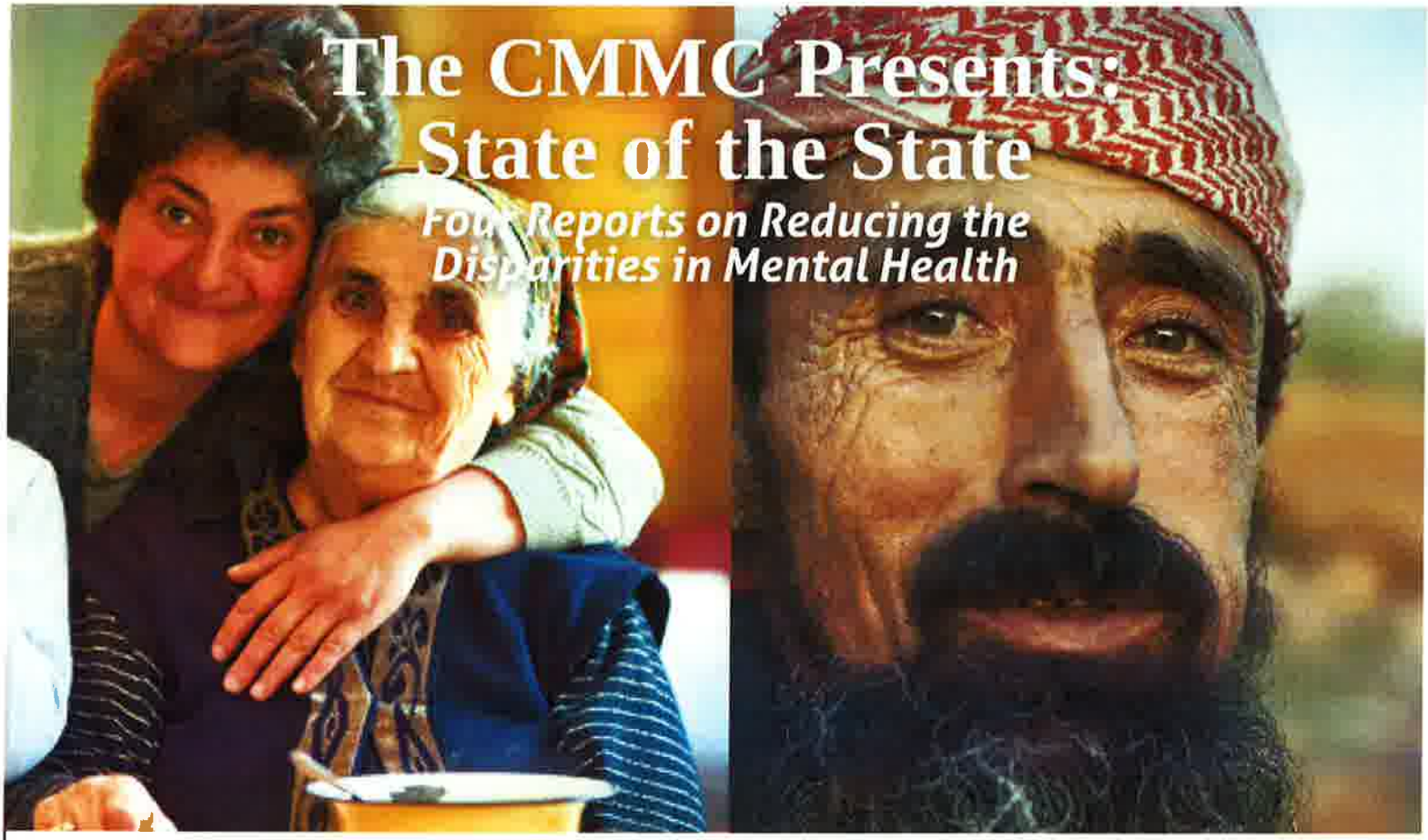
	Individuals with Intellectual/Developmental Disabilities	from community?	• Challenges as identified in the report • Success as identified in the report • Recommendations as identified in the report
1:45 pm 45 min	Presentation 5: Women and Older Adults	Key informant from report? MAC member from community?	• Who we are • Our history • Challenges as identified in the report • Success as identified in the report • Recommendations as identified in the report
2:30 pm 30 min	Roundtable Activity 1	Community members/presenter	Each community or panel/report is set up at a table. Attendees are able to join the community of their choice to ask questions and exchange in a dialogue with the representative from that community/report A scribe will take notes on a flipchart so that participants in the next group are able to see what previous groups talked about.
3:00 pm 30 min	Roundtable Activity 2	Community members/presenter	Each community or panel/report is set up at a table. Attendees are able to join the community of their choice to ask questions and exchange in a dialogue with the representative from that community/report A scribe will take notes on a flipchart so that participants in the next group are able to see what previous groups talked about.
3:30 pm 30 min	Roundtable Activity 3	Community members/presenter	Each community or panel/report is set up at a table. Attendees are able to join the community of their choice to ask questions and exchange in a dialogue with the representative from that community/report

Addressing Mental Health Disparities:
A presentation on the five State of the State Reports

2015

10:00 am – 3:00 pm

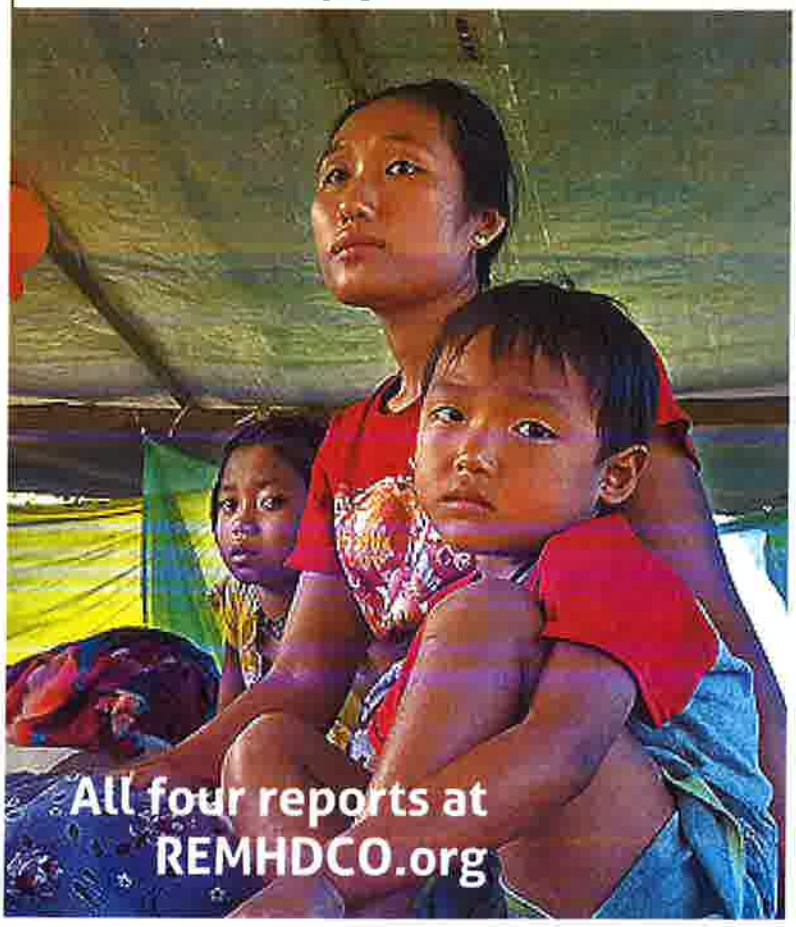
			A scribe will take notes on a flipchart so that participants in the next group are able to see what previous groups talked about.
4:00 pm 30 min	Roundtable Activity 4	Community members/presenter	Each community or panel/report is set up at a table. Attendees are able to join the community of their choice to ask questions and exchange in a dialogue with the representative from that community/report A scribe will take notes on a flipchart so that participants in the next group are able to see what previous groups talked about.
4:30 pm 30 min	Roundtable Activity 5	Community members/presenter	Each community or panel/report is set up at a table. Attendees are able to join the community of their choice to ask questions and exchange in a dialogue with the representative from that community/report A scribe will take notes on a flipchart so that participants in the next group are able to see what previous groups talked about.
5:00 pm	Adjourn Closing Remarks	CMMC Member	

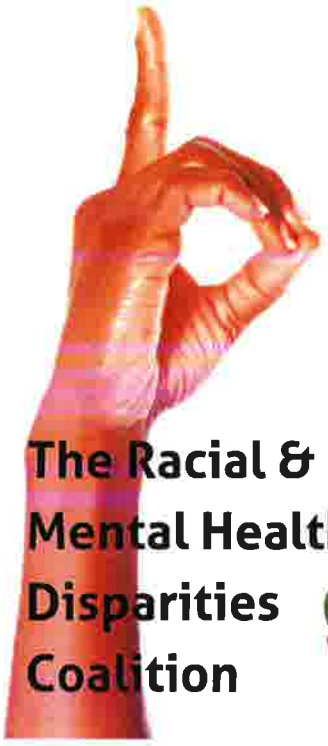


The CMMC Presents: State of the State

Four Reports on Reducing the Disparities in Mental Health

Penetration Rates
Armenian & Deaf/Hard of Hearing Communities
Russian Speaking, Middle Eastern, Southwest Asian Communities
Refugee & Individuals w/Intellectual/Developmental Disabilities





The Racial & Ethnic Mental Health Disparities Coalition

Report Dissemination Ideas

1. **Conferences**

   Highlight the reports at conferences that members are already planning to attend. Submit abstracts for poster sessions, individual or panel presentations. Reports can also be disseminated via tabling.

   The report/s disseminated will be chosen according to what is most relevant to the topic/audience of the conference.

   Volunteers will be needed to identify conferences as well as attend and present at conferences.

2. **Meetings**

   Share reports at the meetings members are attending. Again, the report/s disseminated will be chosen according to what is most relevant to the topic/audience of the conference.
   Ideally, we will be on the agenda and not just sharing during general public comment.

   Meeting examples: CMHPC, OAC, CalMHSA, MHSA Partners, partnering CBOs, etc.

   Volunteers will be needed to identify meetings as well as attend and present at meetings.

3. **Email**

   Post reports on REMHDCO website and share with email lists.

   Examples: Social work listservs, counseling listservs, etc.

   Erin will come up with a form email. MAC members will need to share the email and reports with their lists.

4. **Panel Event/Briefing**

   After the fifth and final report is complete, hold a panel/briefing event to highlight all reports. Press can also be invited to this event.

   Event should piggyback on another event to help with cost and with attendance.

5. **Webinar Series**
   After panel event, five webinars (one per report) that allow for discussion on the findings and questions from attendees. Five webinars (lasting 30 min to 1 hour), one per report.

   Erin will work on draft agendas for series. Volunteers will be needed to present on the webinars.

Other

- Create one pager per each report that can easily be handed out during meetings or at conferences. These docs should have enough info to peek the readers interest and have them read the entire report
- One pager that highlights all 5 reports

Work with Emerging Leaders when possible.

VIII.

Review of CalMHSA RFP

Voice of the underserved

CMMC

California MHSA Multicultural Coalition

MEMBERS

Sergio Aguilar-Gaxiola

John Aguirre

Michelle Alcedo

Jack Barbour

Rocco Cheng

Viviana Criado

Stephen Garrett

Jim Gilmer

Jamila Guerrero-Cantor

Shaista Jaffri

Janet King

Nga Le

Beatrice Lee

Jessica LePak

Yvette McShan

Poshi Mikalson

Raja Mitry

Masa Nakama

Ahmed Nmer

Emma Oshagan

Christina Quiñonez

Mari Radzik

Brandon Ruiz-Williams

Two Feathers Tripp

Russell Vergara

Gulshan Yusufzai

Memo for VIII – CalMHSA's RFP "Reaching California's Diverse Communities to Achieve Mental Health and Wellness"

On the evening of Monday, March 16th, I received notice from CalMHSA (the California Mental Health Services Authority – a joint powers authority made up of County Behavioral Health departments) regarding their Phase Two Prevention and Early Intervention RFPs.

I sent notice of this to CMMC members and interested parties. (By the time of the CMMC meeting on the 25th, the proposer's webinar will have been completed.)

Since the title of the RFP seems to indicate that they are trying to reach underserved communities, it seemed appropriate for the CMMC to review. The proposal can be accessed on the CalMHSA website but here is the address to the webpage:

http://calmhsa.org/wp-content/uploads/2015/03/CalMHSA-RFP1-Final-v3-13-15.pdf

A limited number of copies of this RFP will be available when we discuss it at the CMMC meeting, but it would be appreciated if you downloaded it yourself if you wish to make comments or ask questions during discussion.

Stacie Hiramoto

From: Laura Li <laura.li@calmhsa.org>
Sent: Monday, March 16, 2015 7:25 PM
To: Stacie Hiramoto
Subject: CalMHSA Releases Request for Proposal (RFP) CalMHSA:0024724
Attachments: CalMHSA RFP1 Final v3-16-15.pdf

CalMHSA RELEASES REQUEST FOR PROPOSAL (RFP)

Statewide Phase Two Prevention and Early Intervention (PEI) Programs

Program One: Reaching California's Diverse Communities to achieve Mental Health Awareness

CalMHSA would like to announce the release of its Statewide Phase Two PEI Programs RFP, Program One: Reaching California's Diverse Communities to Achieve Mental Health Awareness. The Purpose of Program One is to further disseminate and support the local use of mental health awareness and suicide prevention tools and resources developed under the Each Mind Matters umbrella to effectively reach California and its diverse communities.

For access to the full RFP visit the CalMHSA website at www.calmhsa.org or click on the following below:
http://calmhsa.org/wp-content/uploads/2015/03/CalMHSA-RFP1-Final-v3-13-15.pdf

(Please note important timelines found on page two of the RFP.)

We ask that you please distribute this RFP far and wide to allow for maximum distribution.

NOTE: Proposer's Webinar scheduled for March 23, 2015, is strongly recommended. Questions related to this RFP should be submitted in writing prior to the webinar.

Laura Li
JPA Administrative Manager
California Mental Health Services Authority
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670
(916) 859-4818
www.CalMHSA.org
(855) 226-4572

IX.

CMMC Administration Committee Report

CMMC Administration Committee
Report for the CMMC In-Person Meeting of
March 25th, 2015

Members of the Administration Committee:

John Aguirre – Co-Chair
Ahmed Nemr – Co-Chair
Jim Gilmer
Yvette McShan
Raja Mitry
Russell Vergara

I. Approval of the Policy on CMMC Stationery

After discussion on this topic at the December 2014 CMMC meeting and during two CMMC Administration Committee monthly conference calls (January 21, 2015 and February 18, 2015), the proposed policy on the use of CMMC stationery was developed and follows. This allows for a member to remove his or her name on letters involving an issue requiring a vote of the CMMC.

ACTION: This policy may be voted on today OR may be voted on at the June 23-24, 2015 meeting.

II. Approval of the Policy on Voting by Email

After discussion on this topic at the December 2014 CMMC meeting and during two CMMC Administration Committee monthly conference calls (January 21, 2015 and February 18, 2015), the proposed policy on CMMC members voting by email was developed and follows. This specifies the process and other specifications regarding responses by members.

ACTION: This policy may be voted on today OR may be voted on at the June 23-24, 2015 meeting.

III. Review of New Year 5 Deliverables for the CMMC

Staff is happy to report that the CMMC received a contract extension which will provide the opportunity for additional time for the CMMC to complete its deliverables. It also provides the opportunity to disseminate the State of the State and Special reports, as well as conduct two-day CMMC in-person meetings.

A matrix of the new deliverables is attached.

CMMC Proposed Policy on Stationery

(For Approval at CMMC Meeting of March 25, 2015)

Background

The preferred CMMC stationery has been designed jointly by co-chair and staff and voted for acceptance in 2014. The names of all the members of the CMMC are listed on the side of the stationery design.

Use of the CMMC Stationery

- For routine letters that did not involve a vote of the CMMC, this stationery with all member names will be utilized. Any such letters sent on behalf of the CMMC will be copied and included in the materials for the next in-person CMMC meeting.

- For a letter involving an issue that required a vote of all the CMMC members whether in-person or email, any CMMC members will be allowed to request that his or her name be removed from the stationery.

    - A reason does not have to be given for this request.
    - The name will be removed upon the request being received by the director
    - This will be done on a case-by-case basis. Request for removal or no request for removal from any CMMC letter will not carry forth to the next letter involving an issue that required a vote.
    - Proposed letters from the CMMC will be sent to all members at least 12 hours prior to a deadline for requests for removal of a name.

Voice of the underserved

CMMC

California MHSA Multicultural Coalition

MEMBERS

Sergio Aguilar-Gaxiola

John Aguirre

Michelle Alcedo

Jack Barbour

Rocco Cheng

Viviana Criado

Stephen Garrett

Jim Gilmer

Jamila Guerrero-Cantor

Shaista Jaffri

Janet King

Nga Le

Beatrice Lee

Jessica LePak

Yvette McShan

Poshi Mikalson

Raja Mitry

Masa Nakama

Ahmed Nmer

Emma Oshagan

Christina Quiñonez

Mari Radzik

Brandon Ruiz-Williams

Two Feathers Tripp

Russell Vergara

Gulshan Yusufzai

[This is the current CMMC stationery]

1127 11th Street, Suite 925, Sacramento, CA 95814 / Phone: (916) 557-1167 / Fax: (916) 447-2350 / info@remhdco.org

CMMC Proposed Policy on Voting by Email

(For Approval at CMMC meeting of March 25, 2015)

Background

There are times when a proposed policy or issue warrants a formal response from the CMMC. There are also times when an administrative action or decision must take place for the organization to move forward in a timely manner. Because the CMMC meets in-person only every three months, it is not always practical or possible to wait until the next meeting for certain votes to take place.

When the leadership of the CMMC determines that a vote cannot wait until the next in-person meeting, the CMMC staff will use group email in order to conduct a vote from all the members of the CMMC.

Procedure

A group email will be sent out by staff to all members of the CMMC that includes:

1. Background information on the issue
2. Proposed vote on the issue
3. Deadline on when the vote must be received in order to be counted.
4. Instructions on getting the vote back to the correct staff person

It is strongly encouraged that all members of the CMMC reply with casting a vote of their choosing based on the information provided, even if abstaining -- as each person's position matters and needs to be recognized.

In each email calling for a vote, it will be stated that:

- Non-response by any CMMC member will be counted as an "Abstention". In other words, if the designated staff does not receive an email in response to the request for a vote, this will be the same as "Not Voting"

- The vote does not require a quorum, but a simple majority of those voting. The majority of members of the CMMC do not need to respond in order for a vote to be considered valid. As an example, if 4 "Aye" votes are received and 3 "No" votes are received (and 20 do NOT respond), the measure will be considered to have passed.

CMMC Contract Deliverables
Year 5

Task 6: Compliance with Monitoring and Reporting Requirements	RESPONIBLE CMMC COMMITTEE	DELIVERABLE DUE DATE	INVOICE DATE	COMMENTS
Quarterly Progrees/Activity Report (QPAR)				
Quarter 1			4/30/15	
Quarter 2			7/31/15	
Quarter 3			10/31/15	
Final Report (Quarter 4)			1/31/16	
Program Component Total				
Contract Total				

CMMC Contract Deliverables
Year 5

Quarter 3			10/31/15	
Quarter 4			1/31/16	
Program Component Total				
Task 2: Establish Emerging Community Leaders Mentorships	**RESPONSIBLE CMMC COMMITTEEE**	**DELIVERABLE DUE DATE**	**INVOICE DATE**	**COMMENTS**
a. Emerging Community Leaders Mentorships Report	EMERGING LEADERS		1/31/16	
b. Report of Training Outcomes for Emerging Community Leadership Mentorship Program	EMERGING LEADERS			
First half of year			4/30/15	
Second Half of Year			1/31/16	
Mentorship plan	EMERGING LEADERS		7/31/15	
Program Component Total				
Task 3: Foster Cross-Agency Collaboration	**RESPONSIBLE CMMC COMMITTEEE**	**DELIVERABLE DUE DATE**	**INVOICE DATE**	**COMMENTS**
a. Quarterly Cross-Agency Collaboration Report: Contractor, County, and Other Key Stakeholder Outreach and Engagement Activities				
Quarter 1			4/30/15	
Quarter 2			7/31/15	
Quarter 3			10/31/15	
Quarter 4			1/31/16	

CMMC Contract Deliverables
Year 5

b. CRDP All Contractors Meeting				
All contractors meeting #1			4/30/15	
f. Final report summarizing the implementation of the CRDP Strategic Plan and recommendations for next steps (Update in Y4-Y5)	STRATEGIC PLAN	6/30/2015		
All contractors meeting #2			7/31/15	
All contractors meeting #3			10/31/15	
Program Component Total				
Task 4: Support the Implementation of the CRDP Strategic Plan	**RESPONIBLE CMMC COMMITTEE**	**DELIVERABLE DUE DATE**	**INVOICE DATE**	**COMMENTS**
a. CRDP Strategic Plan Implementation Recommendations Report	STRATEGIC PLAN		7/31/15	
Program Component Total				
Task 5: Assessment of MHSA Implementation and Identification of Solution-Based Recommendations to Reduce Disparities	**RESPONIBLE CMMC COMMITTEE**	**DELIVERABLE DUE DATE**	**INVOICE DATE**	COMMENTS
a. State of the State Report	MAC		7/31/15	
b. Special Report	MAC		7/31/15	
c. State of the State/Specfial Report Work Plan	MAC		4/30/15	
d. Dissemination Plan and Report Out of Implementation Activities	MAC		1/31/16	
Program Component Total				

CMMC Contract Deliverables
Year 5

Task 6: Compliance with Monitoring and Reporting Requirements	RESPONIBLE CMMC COMMITTEE	DELIVERABLE DUE DATE	INVOICE DATE	COMMENTS
Quarterly Progrees/Activity Report (QPAR)				
Quarter 1			4/30/15	
Quarter 2			7/31/15	
Quarter 3			10/31/15	
Final Report (Quarter 4)			1/31/16	
Program Component Total				
Contract Total				

CMMC ADMINISTRATION COMMITTEE

Conference Call
Wednesday, January 21st, 2015
4:00pm – 5:30pm

NOTE NEW CONFERENCE NUMBERS
Dial: (800) 410-3590 Passcode: 7201208#

DRAFT AGENDA

Co-Chairs Ahmed Nemr and John Aguirre

Attendance: Ahmed Nemr, Raja Mitry, Yvette McShan

Not in attendance: Jim Gilmer, John Aguirre, Russell Vergara, Christina Quinonez

Staff: Michael Helmick, Stacie Hiramoto

I. Introductions
   a. Discussed an Arab-American training that Raja participated in in San Mateo county
II. Review of meeting notes from November 19th and Draft Meeting Notes of the CMMC In-person meeting of December 11th, 2014
   a. Two points from Ahmed
      i. What is our decision on policy regarding emails asking for a response
         1. No-response would be counted as an abstain
         2. Majority of members voting must say yes
         3. Must have gone through one of the committees
         4. Action item: Stacie will draft a description/policy which states when a committee proposes something and the CMMC is asked to approve some type of action, then if we do not receive any vote it will be considered an abstain

a. Note that only a simple majority vote of those members that choose to vote is needed for approval of any action.

ii. What is our policy for names on letterhead?

1. The current policy is to start with all names on the letterhead, and only remove a name if someone requests their name removed.
2. Action item: Stacie to write policy starting with all names on letterhead and only removing names by request on case by case basis.
3.

List any follow-up to do and any issues that this committee needs to take up in the future.

III. Draft PEI Regulations at the OAC Tomorrow – Recap

a. At last OAC meeting more suggested language was made by CMMC members
b. Some sections were accepted, but it appears that they are not including the changes into the version that will be finalized and submitted to OAL

IV. Review of Deliverables for 2015

V. Review of Current Policies and Procedures

VI. Upcoming Dates of Importance

A. MHSOAC In-person meeting
Thursday, January 22nd, 2015
8:30 a.m. – 5:00 p.m.
1325 J Street, 17th Floor
Sacramento, CA 95814
(916) 445-8696

Note that there will be a final public comment period in regards to the proposed PEI regulations in regards to Commission response to the prior public comments.

Here is the link to the agenda:

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2015/January/OAC/OAC_012515_Agenda_FINAL.pdf

B. Next CMMC Administration Conference Call
Wednesday, February 18th, 2015
4:00 p.m. – 5:30 p.m.

C. Next CMMC In-Person Meeting
Probable date: Wednesday, March 25th, 2015 – PLEASE SAVE

This is the day before the MHSOAC meeting and CMMC members will likely be invited to stay over for this meeting.

D. **Dates for Upcoming Public Comment Sessions for the CRDP Draft Strategic Plan.** (Please see the email sent by Stacie on January 13th regarding these meetings.)

a. Action Item: Staff will provide the CMMC with talking points that describe the recommendations from the CMMC

Fresno – Monday, January 26, 2015
9:00 am to 1:30 pm
Fresno Downtown Business Hub
1444 Fulton Street

Oakland – Wednesday, January 28, 2015
9:00 am to 1:30 pm
Nile Hall, Preservation Park
668 13th Street

San Diego – Wednesday, February 4, 2015
9:00 am to 1:30 pm
Sherman Heights Community Center
2258 Island Avenue

Los Angeles – Thursday, February 5, 2015
9:00 am to 1:30 pm
California Community Foundation, Joan Palevsky Center
281 South Figueroa Street, Suite 100

Eureka – Tuesday, February 17, 2015
9:00 am – 1:30 pm
Humboldt County Office of Education Annex
901 Myrtle Avenue

For more information on any of these and to register to participate:

www.cpehn.org

CMMC ADMINISTRATION COMMITTEE

Conference Call
Wednesday, February 18th, 2015
4:00pm – 5:30pm

NOTE NEW CONFERENCE NUMBERS
Dial: (800) 410-3590 Passcode: 7201208#

DRAFT AGENDA

Co-Chairs Ahmed Nemr and John Aguirre

Attendance: Raja Mitry, Jim Gilmer, Bong Vergara,

Not in attendance: Ahmed Nemr, John Aguirre, Yvette McShan

Staff: Michael Helmick & Stacie Hiramoto

I. Introductions

II. Review of meeting notes from January 21st

a. CMMC made a wonderful appearance at all CRDP Strategic Plan town halls.
b. We had attendees at all four forums

III. Review of Proposed Policies

A. Policy on Voting by Email
a. The current problem is that not enough people respond to time sensitive requests
b. Raja has suggested language:
i. It is strongly encouraged for all CMMC members to respond, promptly, with a response, whether that is aye, nay, or abstain.
ii. Language sent by Raja via email to Michael:

iii. "It is strongly encouraged that all members of the CMMC reply with casting a vote of their choosing based on the information provided, even if abstaining -- as each person's position matters and needs to be recognized. "
iv. Non-response by any CMMC member will be counted as an "Abstention". In other words, if the designated staff does not receive an email in response to the request for a vote, this will be the same as "Not Voting"
v. Jim approves staff recommendations

B. Policy on CMMC Stationery Use
   a. Should we allow members the opportunity to, on a case by case basis, remove their name from the stationery?
      i. Most people prefer to have their name on the list
      ii. The committee chooses to allow members, on a case by case basis, to remove

IV. Review of Committee Deliverables

Someone on the committee needs to take charge of facilitating the review of these at each conference call.
   a. Jim: Should this be a job of the co-chairs?
      a. Not necessarily, they are tasked with facilitating the conference calls and providing feedback to the CMMC
      b. Action item: We will put this on the agenda so that the co-chairs are present during the discussion
      c. Raja has offered to aid Stacie in the completion of this task
   b. The way the contract is structured we must provide written proof that the deliverables are completed
      a. This would give the committee a better understanding of the timeframe for deliverables
   c. We will put two or three on agenda for next conference call

V. Review of the LULAC Report on Behavioral Health Services and Resources for Latinos in Ventura County

This report will be presented at the MHSOAC in-person meeting of February 26th, 2015.
   a. This isn't a deliverable but is very important to make the CMMC aware of it

b. We don't really have time for a CMMC position but it might be helpful to have some with knowledge about the report at the OAC
c. We can include that these issues occur for most racial and ethnic communities
d. We will pay for members who would like to attend

VI. Review of the Little Hoover Commission Report on Proposition 63

This report will also be presented at the MHSOAC in-person meeting of February 26th, 2015.

a. This isn't a deliverable but is very important to make the CMMC aware of it
b. Will be having the initial review on the LHC report
c.

VII. Upcoming Dates of Importance

A. MHSOAC In-Person Meeting for February
Thursday, February 26, 2015
8:30 a.m. – 4:00 p.m.
1325 J Street, Suite 1700
Sacramento, CA 95814

See agenda attached.

B. Next CMMC Administration Committee Conference Call
Wednesday, March 18th, 2015
4:00 p.m. – 5:30 p.m.

C. Next CMMC In-person Meeting
Wednesday, March 25th, 2015
Sacramento – Location TBD

Any member wishing to stay over for the MHSOAC meeting the next day should contact Michael Helmick to make arrangements.

D. MHSOAC In-Person Meeting for March
Thursday, March 26th, 2015
1325 J Street, Suite 1700

Sacramento, CA 95814

CMMC ADMINISTRATION COMMITTEE

Conference Call
Wednesday, March 18th, 2015
4:00pm – 5:30pm

(800) 410-3590 Passcode: 7201208

DRAFT AGENDA

Co-Chairs Ahmed Nemr and John Aguirre

I. Introductions

II. Review of Meeting Notes from Conference Call of February 18th

III. Review of New Contract Deliverables and Schedule

All the CRDP Partners - the 5 SPWs, CPEHN, and REMHDCO - received extensions to their original contract in Phase I (but still part of Phase I). REMHDCO was notified of their extension on Friday, March 6th.

Instead of finishing at the end of June 2015, the CMMC will now be able to operate at least until December of 2015. In addition, the deliverables were both streamlined and some additional deliverables were included.

It is staff's request that the Administration Committee present this new information to the CMMC at the March 25th meeting.

Please see the new contract deliverable matrix and description of deliverables.

IV. The Little Hoover Commission at the CMMC Meeting Next Week

A. The CMMC was very fortunate that the Little Hoover Commission agreed to present their second report on Proposition 63, "***Promises Still***

to Keep: A Decade of the Mental Health Services Act" at our meeting on Wednesday, the 25th! This report has generated renewed interest and questions about the MHSA and general public will be invited to the CMMC to listen to the report and make comments.

This is also an opportunity for the general public to see what the CMMC is all about.

B. This report will also be discussed at the MHSOAC meeting the next day, March 26th. It is important that CMMC members be prepared to give relevant public comment.

V. Other Items of Interest to CMMC members at the MHSOAC Meeting

A. The LULAC report regarding the Latino Community and the Ventura County Behavioral Health Department

B. The Scope of Work for the Client Stakeholder Contract RFPs

V. Important Dates and Events Coming Up

A. MHSOAC Town Hall Meeting
3:00 p.m. – 6:00 p.m.
Thursday, March 19th, 2015
Courtyard by Marriott
1350 Holiday Lane
Fairfield, CA 94534

C. Orientation for New Emerging Leader, Brandon Ruiz-Williams
Welcome Dinner, Tuesday, March 24th

D. Next CMMC Administration Committee Conference Call
April 15, 2015
4:00 p.m. – 5:30 p.m.

E. Deadline for Comments on the draft RFPs for Phase II of the CRDP
March 25th, 2015*

*REMHDCO did ask that this date be moved to Monday March 30th, but we have not heard back from the Office of Health Equity yet.

X.

CMMC Strategic Plan Committee Report

CMMC STRATEGIC PLAN COMMITTEE
Conference Call
Friday, December 19th, 2014
10:00 a.m. – 11:00 a.m.

Dial: (800) 410-3590 Passcode: 7201208*
PLEASE NOTE THIS IS A NEW SET OF NUMBERS

Call Chaired by Viviana Criado

DRAFT AGENDA

Attendance: Viviana Criado, Nga Le, Ruben Cantu, Kimberly Knifong, Rocco Cheng, Katherine Elliott
Staff: Stacie Hiramoto, Michael Helmick

I. Introductions and possible adjustment of the agenda

II. The Public Release of the Draft CRDP Strategic Plan

a. Ruben discussed the current and future steps that CPEHN and the OHE will be taking in regards to the CRDP strategic plan.
b. Planning community forums and welcome any input from the public
c. The CMMC has submitted a letter describing their feedback to the draft strategic plan (Submitted in late 2013)
d. Ruben says he will take the raw data that was submitted by the CMMC in that letter and summarize it into points that he can use going forward
e. Action item: Stacie and Katherine will develop language and points to be given to CMMC members for use at strategic plan community forums.

The draft CRDP Strategic Plan was released, at last, to the public on November 25th. CPEHN plans to have public forums beginning in January to collect information from the public on this historic document.

A. What next steps (if any) should this committee and the CMMC as a whole take in regards to the release of the draft CRDP Strategic Plan?

B. Options to consider

1. Re-review the draft Strategic Plan and the comments from the CMMC which were developed back in August of 2013.

2. Should additional comments be made by the CMMC as a whole? Or should members just go ahead and make comments as individuals?

3. The timeline is tight. If either of the above were to take place, the questions are "***who***" and "***how***"?

4. How should the CMMC participate in the statewide community forums to comment on the draft Strategic Plan?

5. Any other considerations

III. Upcoming Dates of Importance

A. Next CMMC Strategic Plan Conference Call
Friday, January 16th, 2015
10:00 a.m. – 11:30 a.m.

B. Next MHSOAC In-Person Meeting
Thursday, January 22nd, 2015
1325 J Street, 17th Floor
Sacramento, CA 95814

CMMC STRATEGIC PLAN COMMITTEE
Conference Call
Friday, January 23rd, 2014
10:00 a.m. – 11:00 a.m.

Dial: (800) 410-3590 Passcode: 7201208*
PLEASE NOTE THIS IS A NEW SET OF NUMBERS

Call Chaired by Viviana Criado

Attendance: Viviana Criado, Katherine Elliott, Ruben Cantu, Nga Le, Janet King
Not in attendance: Jack Barbour, Sergio Aguilar-Gaxiola, Rocco Cheng
Staff: Michael Helmick, Erin Reynoso, Stacie Hiramoto

DRAFT AGENDA

I. Introductions and review of agenda

II. Review of Meeting Notes for December 19th, 2014

III. Review of Talking Points for CMMC Members

This is a draft of talking points summarizing the CMMC collective comments on the draft Strategic Plan (from August 2013) that can be distributed to the CMMC members.

The committee should make sure these are acceptable because the Town Hall Meetings begin on Monday, January 26th.

1. Created "Talking points" to be given to CMMC members for presentation at CRDP Strategic plan townhalls
    a. If members give insight beyond the talking points we will make clear that they must designate that they are not speaking on approved CMMC comments

b. We will also designate CMMC members that have not commonly presented on behalf of the CMMC
c. Action item: Staff will call CMMC members to attempt to get representation at all community townhalls

2. Talking points overview from Katherine:
   a. Theme 1- Emphasizing local organizations
   b. Theme 2- More money needs to be allocated
      i. Ruben- We need to make it very clear that we are discussing Phase 1 and that any additional money would be down the line
   c. Theme 3- Ensure funding is flexible
   d. Theme 4- Accountability
   e. Ruben: Make sure everyone explains that the CMMC has played a very active role in the development of the Strategic Plan

IV. Status update on other deliverables

V. Review of Meeting Notes of December 11th CMMC meeting

VI. Important Dates Coming Up

A. MHSOAC In-person meeting
Thursday, January 22nd, 2015
8:30 a.m. – 5:00 p.m.
1325 J Street, 17th Floor
Sacramento, CA 95814
(916) 445-8696

Note that there will be a final public comment period in regards to the proposed PEI regulations in regards to Commission response to the prior public comments.

Here is the link to the agenda:

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2015/January/OAC/OAC_012515_Agenda_FINAL.pdf

B. Next CMMC Strategic Plan Committee Conference Call
Friday, February 20th, 2015

10:00 a.m.- 11:30 p.m.

C. **Next CMMC In-Person Meeting**
Wednesday, March 25th, 2015 – PLEASE SAVE

This is the day before the MHSOAC meeting and CMMC members will likely be invited to stay over for this meeting.

D. **Dates for Upcoming Public Comment Sessions for the CRDP Draft Strategic Plan.** (Please see the email sent by Stacie on January 13th regarding these meetings.)

Fresno – Monday, January 26, 2015
9:00 am to 1:30 pm
Fresno Downtown Business Hub
1444 Fulton Street

Oakland – Wednesday, January 28, 2015
9:00 am to 1:30 pm
Nile Hall, Preservation Park
668 13th Street

San Diego – Wednesday, February 4, 2015
9:00 am to 1:30 pm
Sherman Heights Community Center
2258 Island Avenue

Los Angeles – Thursday, February 5, 2015
9:00 am to 1:30 pm
California Community Foundation, Joan Palevsky Center
281 South Figueroa Street, Suite 100

Eureka – Tuesday, February 17, 2015
9:00 am – 1:30 pm
Humboldt County Office of Education Annex
901 Myrtle Avenue

For more information on any of these and to register to participate:

www.cpehn.org

CMMC Strategic Plan Committee Call Agenda
Friday, February 27, 2015
10:00 am – 11:30 am
Dial: 1 (800) 410-3590 – Passcode: 7201208

Facilitator: Viviana Criado

Attendance: Viviana Criado, Katherine Elliot, Nga Le, Ruben Cantu
Staff: Erin Reynoso
Not in attendance: Rocco Cheng, Janet King

I. **Roll Call and Review of Agenda**

II. **Review & Approve January 23rd Minutes**

III. **Recap of Strategic Plan Town Hall Meetings**

- **We had a very good showing.**
  - LA, 83, and Oakland, 82, were largest
  - Fresno, 31, San Diego, 45, Eureka, 23, for a total of over 260 people
  - Attendance at all town halls was diverse
  - Big issues:
    - Data collection and disaggregation of data
    - Cultural competent workforce
    - Sustainability of pilot projects beyond 4 years
    - Intersection of identity
    - Community-defined best practices not viewed under "Western" approach
    - Trauma (Regugee/Asylee and also trauma that occurs to people of color here in the US)
    - Rural community needs
    - Veterans
  - Reviewing notes from town halls and comments received via mail and email
- In process of planning a SPW meeting to receive further feedback

IV. **Status update on other deliverables**

- Program Component 4A Questions to Consider:

1) Last year we gave some recommendations for the identification of funding to implement the CRDP phase 2. Do we have any new ideas given changes over the past year? Any different funding mechanisms or sources that we can recommend?

2) In terms of the ways in which input has been garnered from multicultural communities, what are your thoughts? Has it been effective so far? Are there more effective ways? More strategies? Different approaches?

- We have been approved by OHE to use some of the things we have been doing as deliverable
- We have three left
    - 1st- Recommendations for identifying forms of funding
        - Have we done this already?
            - Viviana- I feel like we can advocate for additional funding for phase 2.
            - Many people at the townhalls asked for this
            - Erin- CMMC can't advocate for specific policy, but we could draft a letter of recommendation educating on budget issues
            - So we will summarize our previous recommendations but main focus will be highlighting interdisciplinary collaboration of funds
    - Ways to garner input from multicultural communities
        - Nga- Are they accepting comments only at town halls, or are they accepting comments online?
        - We need forums actually in diverse communities
        - Katherine- Is there anything Ruben thinks we can help with or provide to aid him?
            - We need to make sure we have enough resources to provide even more outreach events.
            - If we had more resources we would have done much more than 5 town hall events.
    - 3rd- Summary of how implementation is going overall
    - Action item: Erin will set up a call with Kimberly to discuss the recommendations.
        - Letter will go directly to the Department to let them know that much work still needs to be done.

V. Dates of Importance

- Save the Date! Next CMMC Meeting: March 25, 2015
  Please let Michael know if you plan to stay over and attend the OAC meeting the following day

- Next OAC Meeting: March 26, 2015
    - There will be taskforce to further discuss the Little Hoover recommendations
- Next Strategic Plan Call: March 20, 2015

Strategic Plan Committee Year 5 Deliverables

Task 4: Support the Implementation of the CRDP Strategic Plan

The CMMC shall be required to provide input on the implementation of the CRDP Strategic Plan including advice regarding the roll out of the strategies and approaches identified in the CRDP strategic Plan, including identifying strategies to ensure adequate funding for implementation. The Contractor shall describe how the CMMC will provide support in the implementation phase.

Task 4A: CRDP Strategic Plan Implementation Recommendations Report

The Contractor shall provide written recommendations on the identification of best practices for the implementation of the CRDP Strategic Plan. The plan shall include the following:

d) Written recommendations about the method for roll-out of the strategies and approaches identified including statewideness, funding, etc.

e) Work plan for solicitation of input from multicultural communities regarding the implementation, roll-out and effectiveness of the Strategic Plan;

f) Work plan for selection and support of entities to conduct evaluation of identified strategies/approaches;

g) Contribution to the development of evaluation methodology through support of the evaluators;

h) Final report summarizing the implementation of the CRDP Strategic Plan and recommendations for next steps (Update); and

i) Follow-up report on the integrity of the CRDP implementation for the CMMC perspective

Deliverable Due Date: The report shall be submitted by December 1, 2015

Voice of the underserved

CMMC
California MHSA Multicultural Coalition

MEMBERS

John Aguirre
Michelle Alcedo
Jack Barbour
Viviana Criado
Stephen Garrett
Jim Gilmer
Co-Chair
Jamila Guerrero-Cantor
Shaista Jaffri
Janet King
Nga Le
Beatrice Lee
Jessica LePak
Yvette McShan
Raja Mitry
Masa Nakama
Ahmed Nmer
Emma Oshagan
Christina Quiñonez
Mari Radzik
Two Feathers Tripp
Russell Vergara
Co-Chair
Gulshan Yusufzai

Comments by the California MHSA Multicultural Coalition (CMMC) on the California Reducing Disparities Project (CRDP) Draft Strategic Plan

The following document is a compilation of the comments by individuals of the California MHSA Multicultural Coalition – the CMMC. The CMMC is one of the seven partners in Phase I of the California Reducing Disparities Project.

Because of the importance of the CMMC in the overall project, the CMMC reviewed a draft of the Strategic Plan in August of 2013. Over a two-day period, CMMC members went through a detailed process to ensure all members had opportunities to respond to a series of questions regarding the draft Strategic Plan. These questions ensured an appropriate and comprehensive review of multiple aspects of the draft Strategic Plan.

We hope these comments interest and inspire you as you give your input on this long-awaited document.

If you have any questions, please do not hesitate to contact us!

Viviana Criado
Chair – CMMC Strategic Plan Committee
viviana.criado@gmail.com

California MHSA Multicultural Coalition

Comments on the Reducing Disparities Strategic Plan

This document is a summary of feedback on the Strategic Plan to Reduce Mental Health Disparities Draft Document collected through a structured roundtable process conducted over the course of a one-day meeting on August 27, 2013. The feedback is reviewed in detail in a document presented to the California Pan Ethnic Health Network. The following are key points derived from this document.

1) EMPHASIZE LOCAL EFFORTS

To ensure that local communities are at the center of the CRDP project:

a) funding should go directly to local organizations

b) capacity building efforts should be directed at local cbos for

  i) applying for funding and securing contracts

  ii) conducting evaluation

  iii) developing sustainability plans

c) community participation is critical, use methods like Community Based Participatory Research (CBPR), and engage in systematic outreach and engagement of communities from initial phases of project to implementation and evaluation.

d) program requirements should include flexibility to support traditional cultural practices

2) EMPHASIZE CONTINUED AND INCREASED FUNDING

Appropriately funding this historic effort is essential to the long term success of this initiative; therefore the Office of Health Equity must work in close coordination with local and federal entities to successfully secure funding to adequately address the mental health needs of California's diverse communities.

3) OVERSIGHT AND DECISION MAKING BY STATE AND LOCAL COMMUNITIES

The CMMC recommends that local communities be at the forefront of decision making. Community advisory boards should include community leaders; board members should be empowered to promote systems change and positive participatory decision-making, and should operate autonomously from state and county governance. Accountability should be community driven. Oversight for these projects should be conducted primarily by local Community Based Organizations in collaboration with the Office of Health Equity.

4) ATTENTION TO CULTURAL COMPETENCE IN ALL ASPECTS OF IMPLEMENTATION

Requests for Proposals and other project documents must ensure cultural responsiveness including in language appropriateness (avoidance of stigmatizing terminology, attention to cultural idioms), sensitivity to LGBTQ populations across all groups, attention to how family relationships differ across cultures.

5) SUSTAINABILITY AND RECOGNITION OF COMMUNITY DEFINED PROGRAMS

These programs are critical to the mental health of diverse communities. Emphasis must be placed on ensuring that these programs receive sustained support from traditional funding streams. It is critical to develop and implement a process for community programs to achieve status on the level of Evidence Based Practices.

XI.

Director's Report

ASSEMBLY BILL No. 253

Introduced by Assembly Member Roger Hernández

February 9, 2015

An act relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 253, as introduced, Roger Hernández. Mental Health Services Act.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund to fund various county mental health programs, and establishes the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the act.

This bill would state the intent of the Legislature to enact legislation to ensure the appropriate oversight mechanisms are in place to capture the best practices at the county level in order to ensure that veterans have access to the services provided by the act.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to enact legislation to ensure the appropriate oversight mechanisms are in place to capture the best practices at the county level in order to

ensure that veterans have access to the services provided by the Mental Health Services Act.

O

XII.

Discussion of Agenda Items for MHSOAC

Voice of the underserved

CMMC

California MHSA Multicultural Coalition

MEMBERS

Sergio Aguilar-Gaxiola

John Aguirre

Michelle Alcedo

Jack Barbour

Rocco Cheng

Viviana Criado

Stephen Garrett

Jim Gilmer

Jamila Guerrero-Cantor

Shaista Jaffri

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Emma Oshagan

Christina Quiñonez

Mari Radzik

Brandon Ruiz-Williams

Two Feathers Tripp

Russell Vergara

Gulshan Yusufzai

Memo for XII – Discussion of Agenda Items for the MHSOAC Meeting of March 26, 2015

We are hoping that many of the CMMC members can stay for MHSOAC meeting the next day because there are agenda items of great importance to reducing disparities.

The MHSOAC agenda follows this memo. In particular, please note:

Agenda Item 4A: Adopt Outline of Scope of Work for the Client Stakeholder Contract Request for Proposals

Agenda Item 5A: Response by Ventura County Regarding the LULAC report titled, "Investigative Report on the Perceived Mismanagement and Inequitable Distribution of Behavioral Health Services and Resources to the Latino/a Community in Ventura County"

This report was emailed to you earlier – However, if you would like another copy sent to you, please contact Stacie and she will be happy to send you one.

Agenda Item 6A: Little Hoover Commission Round Table Discussion

As they are presenting to the CMMC, CMMC members are likely to have some comments they would like to make during the Public Comment portion of the agenda.

1127 11th Street, Suite 925, Sacramento, CA 95814 / Phone: (916) 557-1167 / Fax: (916) 447-2350 / info@remhdco.org

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Victor Carrion, M.D.
Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

Thursday, March 26, 2015
8:30 A.M. – 4:00 P.M.

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public on agenda items will be heard only when the respective item is being considered. Comments from the public on other matters not appearing on the agenda will be heard during the General Public Comment period. Generally an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. All public comment must be made in person at the meeting. The Commission will not accept public comment via email, US Mail or by phone. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov.

All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum, unless noted as time specific.

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters, assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting the Chief of Commission Support Services at (916) 445-8696 or email at mhsoac@mhsoac.ca.gov.

8:00 AM **Stakeholder Orientation**
A member of the Client and Family Leadership Committee will conduct a Commission Meeting Orientation for stakeholders who are unfamiliar with meeting procedures, if needed.

8:30 AM **Convene**
Chair Victor Carrion, M.D., will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

8:35 AM **Action**
1A: Approve February 26, 2015, MHSOAC Meeting Minutes
The Commission will consider approval of the minutes from the February 26, 2015, MHSOAC Meeting.

- Public Comment
- Vote

Information
1B: February 26, 2015 Motions Summary
A summary of the motions voted on by the Commission during the February 26, 2015, MHSOAC Meeting.

1C: MHSOAC Evaluation Dashboard
The Evaluation Dashboard provides information on both executed and forthcoming MHSOAC external evaluation and data strengthening contracts, including primary objectives, timelines, and deliverables. Information on internal MHSOAC evaluation and research projects, including project objectives, timelines, and milestones, is also provided.

1D: MHSOAC Plan Review Dashboard
The MHSOAC Plan Review Dashboard provides information on Innovation plan(s)/ update(s) that are scheduled for Commission approval and delineates future Innovation plan(s)/ update(s) that are in the pipeline for consideration. The dashboard also contains a brief staff assessment regarding issues that have been gleaned from the Three-Year Program and Expenditure Plans and Annual Updates.

1E: Calendar
The MHSOAC Calendar provides information on committee charter activities and identifies agenda items that need to be advanced onto the Commission Agenda for consideration. The MHSOAC 2015 Work Plan serves as the foundation for the activity deliverables and projected timelines.

8:45 AM **Action**

2A: Recommendations for Changes to Innovation (INN) Regulations

Presenters: Filomena Yeroshek, Chief Counsel
Deborah Lee, Consulting Psychologist

The Commission will be presented with information regarding the feedback received from the Office of Administrative Law on the Innovation regulations. Staff will also present recommended changes to the Innovation regulations based on the feedback received. The Commission will decide whether to make changes to the Innovation regulations.

- Public Comment
- Vote

9:15 AM **Action (First Read)**

3A: Adopt Annual Update Instructions

Presenter: Kevin Hoffman, Deputy Director

The Mental Health Services Act (MHSA) requires that Counties provide Annual Updates to their Three-Year Program and Expenditure plans. Instructions are developed to capture and standardize the critical elements for the Annual Update as described in the law. The draft copy of the 2015/16 Annual Update instructions are being provided to the Commission for adoption.

- Public Comment
- Possible Vote

9:45 AM **Action**

4A: Adopt Outline of Scope of Work for the Client Stakeholder Contract Request for Proposals

Presenter: Kevin Hoffman, Deputy Director

The Commission will consider approval of an outline for the scope of work for the client contract Request for Proposals (RFP). If approved by the Commission, an external contractor will be selected through a competitive process (RFP) to complete the scope of work and associated deliverables. The goal of the client contract to be awarded by the Commission after the RFP process is to provide, consultation, outreach and engagement, education, and technical assistance and training from mental health clients.

- Public Comment
- Vote

10:15 AM **Information**

5A: Response by Ventura County Regarding the League of United Latin American Citizens (LULAC) report titled, "Investigative Report on the Perceived Mismanagement and Inequitable Distribution of Behavioral Health Services and Resources to the Latino/a Community in Ventura County."

Presenters: Barry Fisher, Health Care Agency Director, Ventura County Health Care Agency
Elaine Crandall, Behavioral Health Director, Ventura County Health Care Agency

On November 1, 2014, the League of United Latin American Citizens (LULAC) released a report regarding perceived mismanagement and inequitable distribution of Behavioral Health services and resources to the Latino/a community in Ventura County. The Commission invited LULAC to the February 26th, 2015 meeting to provide a presentation regarding this report. The Commission has invited and will receive a presentation by the Ventura County Behavioral Health Department regarding their response to the report and a status update on the counties dialogue with LULAC.

- Public Comment

11:00 AM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

11:15 AM **Lunch**

12:30 AM **Information**

6A: Little Hoover Commission Round Table Discussion

Facilitator: Toby Ewing, Executive Director

At the February 26, 2015 MHSOAC meeting, the Commission heard a presentation on the Little Hoover Commission (LHC) report released in January of 2015 entitled, *Promises Still to Keep: A Decade of the Mental Health Services Act*. The report – an assessment of the Mental Health Services Act (MHSA) – includes recommendations regarding MHSOAC authority. As a result of the presentation at the February meeting, the Commission has put together two panels of Subject Matter Experts to discuss issues related to the LHC recommendations and to provide further recommendations to assist the Commission. The Commission is forming a task force to follow up on the issues raised by the panels and the LCH report.

Panel A: The perspective of Department of Healthcare Services, service providers, and the County Behavioral Health Directors Association/ Counties.

Panel B: The perspective of clients, consumers, family members, advocates for children and families, and unserved and underserved communities.

- Public Comment

3:30 PM **Action**

7A Update on the Commission's Stakeholder Orientation

The Commission will discuss the need for the Client and Family Leadership Committee to update the logistics of the Stakeholder Orientation.

- Public Comment
- Vote

3:45 PM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

4:00 PM **Adjourn**

AGENDA ITEM 4A

Action

March 26, 2015 Commission Meeting

Adopt Outline of Scope of Work for the Client Stakeholder Contract Request for Proposals

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of the outline of the scope of work for the client stakeholder contract. This outline will be used to draft a Request for Proposal (RFP) for a client stakeholder contract in an amount not to exceed $1,643,850 for three years, or $547,950 annually.

As part of the Governor's fiscal year 2012/13 reorganization plan, the Department of Mental Health (DMH) was eliminated and the stakeholder contracts were transferred to the MHSOAC.

The client stakeholder contracts were designed to facilitate an inclusive and educated stakeholder process at the local and state level. The client stakeholder contract will provide a statewide network of consumers who will conduct trainings at the local level designed to strengthen local community planning processes, share resources, support MHSOAC community outreach efforts, and provide technical assistance to the MHSOAC regarding local community mental health issues.

In 2012 the Commission conducted an RFP for the client stakeholder contract and that contract will be expire this year, thus the need for this new RFP.

Enclosures: RFP outline for the Client Stakeholder Contract.

Handout: A PowerPoint will be provided at the Commission meeting.

Recommended Action: Adopt Outline of Scope of Work for the Client Stakeholder Contract Request for Proposal.

Presenter: Kevin Hoffman, Deputy Director

Motion: The MHSOAC approves the Draft Outline for a Request for Proposals for the Client Stakeholder Contract.

Mental Health Services
Oversight & Accountability Commission

Request for Proposals (RFP) Outline
for the
Client Stakeholder Contract

Background

As part of the fiscal year 2012/13 State Budget, the Department of Mental Health (DMH) was eliminated and various contracts, services, and budgetary authorities originally granted to DMH were distributed to other state and local entities. Specifically, the funds and authority for a client stakeholder contract, designed to facilitate inclusion of stakeholders, was transferred to the Mental Health Services Oversight and Accountability Commission (MHSOAC). In order to utilize the funds available for client advocacy and to meet statutory mandates, the MHSOAC will develop a request for proposal.

Statutory References

The passage of the Mental Health Services Act (MHSA) initiated, at the state and local levels, the concept of transparent and collaborative processes being implemented to determine the mental health needs, priorities, and services for California mental health consumers. This collaboration is documented in several Welfare and Institutions (W&I) Code sections.

The MHSOAC is mandated in W&I Code Section 5846(c) to "ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations." The client stakeholder contract is one means of ensuring that such perspective and participation occurs.

The stakeholder contract also supports the statutory requirement in W&I Code Section 5892(d) that the Mental Health Services administrative fund "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 delivers, or access to services." In addition, the contract would support the 2012 amendment to the W&I Code Section 5848(a) made by Assembly Bill 1467 that strengthened local stakeholders' involvement by requiring counties to "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations."

Below are the recommended overall principles and outline of the Scope of Work for the Request for Proposals for the client stakeholder contract. These are aligned to meet the above described statutory mandates.

Overall Principles

1. Outputs should be tied to the MHSA and the values of the MHSOAC.
2. Outputs should be tied to the MHSOAC logic model.
3. Outputs should predominately make an impact on the mental health system instead of on the individual level.
4. Provides for consumer outreach and support so that the perspective and participation of diverse community members who are reflective of California populations, including those with lived experience, are a significant factor in the decisions and recommendations made by state agencies, including the MHSOAC.
5. Provides for consumer outreach and support to assist with a robust local stakeholder process.

Outline of Scope of Work

The RFP may include, but not be limited to, the following types of action:

a. Develop or expand upon an existing statewide network of client stakeholders who have lived experience in their local mental health communities, including individuals from diverse ethnic and racial backgrounds. Members of this network will be trained in the MHSOAC curriculum, "Effective and Meaningful Client Stakeholder Participation: A Training on Guiding Principles in Community Planning Process" and conduct trainings for additional client stakeholders at the local level.

b. The statewide network of client stakeholders will utilize their knowledge of their local community to apprise the MHSOAC of trends and issues relevant to client stakeholders regarding the MHSA Community Program Planning process and service provision. The network of client stakeholders will work with the MHSOAC to "Tell the Story" of how MHSA funding and services from the various components are making an impact in local communities.

c. Disseminate the curriculum developed in prior contract titled, "Effective and Meaningful Client Stakeholder Participation: A Training on guiding Principles in Community Planning Process" to local and or regional stakeholder groups in order to expand their ability to effectively participate in their local stakeholder process.'

d. Inventory the Issue Resolution Process at both the state and local levels, and identify ways in which these processes may be strengthened from the client perspective, including, but not limited to, specific gaps in the system, and issues that may be restraining system response. Provide Technical Assistance (TA) and develop work products to assist in TA provision to counties on the development or implementation of a process as necessary.

e. Organize and facilitate two regional summits, one in Northern California and one is Southern California, for peer providers and members of consumer run organizations to allow for opportunities to share resources,

network, highlight important issues, and develop and share best practices.

f. Collect local mental health board reports on the needs and performance of county mental health systems, which are submitted annually to the local Board of Supervisors. Review and analyze the reports and provide a report to the MHSOAC on any and all frequently identified concerns, issues and trends across the counties.

g. Develop, host and maintain a website that will be a statewide resource for information on local community planning efforts, advocacy opportunities, etc.

h. Conduct outreach to diversify and further stakeholder participation at both the local and the state level.

i. Support the work of the MHSOAC community forums by promoting local stakeholder participation at the forums and facilitating a pre-meeting orientation for stakeholders on the forum format and presenting public comment.

j. Conduct local outreach to recruit for MHSOAC focus group participation.

Minimum Qualifications

The following minimum qualifications must be met for the proposal to be read and evaluated. The bidder must:

1. Have evidence of capacity to provide statewide, county-level, and state-level participation.
2. Be a non-profit organization.
3. Have a governing board that is at least fifty-one percent (51%) mental health consumers.
4. Have evidence of a capacity to engage diverse communities reflective of the California population that have been unserved, underserved, or inappropriately served in the mental health system.

AGENDA ITEM 5A

Action

March 26, 2015 Commission Meeting

Response by Ventura County Regarding the League of United Latin American Citizens (LULAC) report titled, "An investigative report on the perceived mismanagement and inequitable distribution of Behavioral Health services and resources to the Latino/a Community."

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will receive a presentation by Ventura County Behavioral Health regarding their response to the League of United Latin American Citizens (LULAC) report titled, "An investigative report on the perceived mismanagement and inequitable distribution of Behavioral Health services and resources to the Latino/a Community."

The report can be found at the following address: http://mhsoac.ca.gov/MHSOAC_Publications/docs/BH_Report_110114_VenturaCoutny.pdf

On November 1, 2014, LULAC released the report titled, "An investigative report on the perceived mismanagement and inequitable distribution of Behavioral Health services and resources to the Latino/a community."

LULAC was invited to the February 26th, 2015 Commission meeting to provide a presentation regarding this report. The Commission has invited and will receive a presentation by the Ventura County Behavioral Health Department regarding their response to the report and a status update on the counties dialogue with LULAC.

Presenters:
- Barry Fisher, Health Care Agency Director, Ventura County Behavioral Health Care Agency
- Elaine Crandall, Behavioral Health Director, Ventura County Behavioral Health Care Agency

Enclosures: MHSOAC Staff Overview of LULAC Report, Ventura County Response to LULAC Report

Recommended Action: None

Handouts: None

Proposed Motion: None

MHSOAC Staff Overview

Of the League of United Latin American Citizens (LULAC) Report

"An investigative report on the perceived mismanagement and inequitable distribution of Behavioral Health services and resources to the Latino/a community"

"Re: Ventura County Behavioral Health-A Publically Funded Agency"

Background:

Commission staff have read the November 1, 2014 report submitted to the Commission by the California League of United Latin American Citizens (California LULAC). As identified by LULAC this is "An investigative report on the perceived mismanagement and inequitable distribution of Behavioral Health services and resources to the Latino/a community" by Ventura County Behavioral Health. This report was delivered to Commission staff at the Commission's mental health forum held in Ventura County on November 6, 2014.

Caveat: What follows are highlights of the findings and observations described in the LULAC report.

To be clear, based solely on reading the LULAC report, there is no way to determine or analyze whether various findings and observations in the report about service and fiscal disparities to the Latino/a community in Ventura County are accurate. As such, what follows is a summary of the observations and findings as described in the LULAC report.

General Complaints Addressed in LULAC Report:

The LULAC report indicates that their investigation was prompted by numerous complaints from local community members, community leaders, several elected officials, and concerned staff from within the Ventura County Behavioral Health (VCBH) department. The report states that the majority of complaints came from the sectors of the county with the largest concentration of people of Mexican descent.

As reported the complaints included:

1. That the Ventura County Behavioral Health management and leadership team maintain a veiled policy of doing as little as necessary to meet the mental health services needs of the Latino community, as compared to the same needs of the White community

2. That the VCBH management and leadership team maintain a covert practice of hiding and altering data and evaluation reports that reveal the failed performance of the agency in reaching and meeting the mental health needs of the Latino community

3. That clinical staff assigned to work in Latino communities are treated disparately as compared to staff assigned to work in White, more affluent communities

4. That repeated recommendations from official evaluation agencies to improve services for the Latino community are ignored by the VCBH management and leadership team

5. That VCBH staff, including managers, who attempt to address recommendations made by external audit and evaluation teams are either ignored or directed to "hold back" on the intended action

LULAC's report begins with describing the procedures used to complete their investigation and definitions of specific terms used throughout the report

Summary of Findings/Observations Contained in LULAC Report:

1. Penetration Rate for Latino/as is less than the state average penetration rate for Anglos. This inequity makes it unsatisfactory. (Penetration rate measures the effectiveness of a County to reach and serve members of a population that are eligible for Medi-cal sponsored mental health services)

2. There is a failure to meet language proficiency needs of Spanish-speaking clients

3. There is a history of recommendations contained in APS Healthcare California External Quality Review Organization (EQRO) reports and documents from the Latino Access Project that indicate a need to improve and increase services to the Latino/a community

4. Appearance that VCBH senior management discounted APS Healthcare EQRO reports and their recommendations

5. Practice of dismissing and/or hiding poor performance findings from stakeholders

6. Disparate treatment of persons with serious mental illness from the Latino/Mexican community who are not provided the same quality and quantity of services being provided to the White population by VCBH

7. Disparate allocation of funding resources to program operators that are representative in appearance and cultural characteristics of the Mexican community. Perception that programs owned and operated by White personnel are greatly favored with funding

8. Disparate treatment of VCBH employees serving the Latino/a community in terms of staff ratio to client population

9. Insensitivity to travel and access to service issues by restricting clients from gaining services from the nearest clinic and instead requiring them to travel to a clinic that is further away

10. Appearance that cultural *incompetence* starts at the top of VCBH

11. Directing Child Welfare Subsystem staff to withhold information from federal compliance officer with regard to the "Katie A" decision that mandated a provision to "accomplish systemic change for mental health services to children and youth" at imminent risk of being placed in foster homes

12. Lack of understanding or appreciation for the value and use of effective outreach to reach and serve under-served populations making outreach to the community non-existent

The report concludes with nine recommended actions to address the LULAC findings. (See Pages 30 – 34 of the report)

As stated previously, based solely on reading the LULAC report, there is no way to determine or analyze whether various findings and observations in the report about service and fiscal disparities to the Latino/a community in Ventura County are accurate.

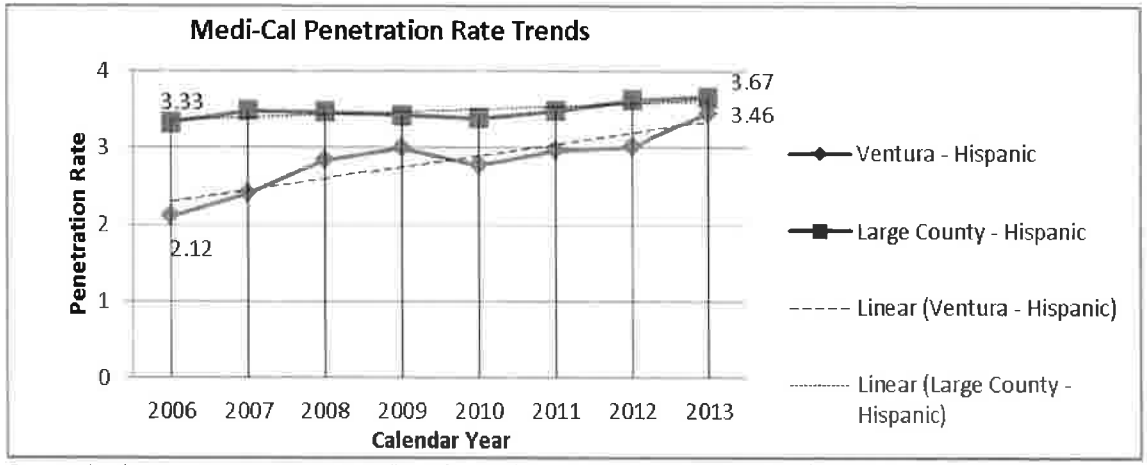
Additional Note: Commission staff have been recently informed by LULAC that they have begun to work with staff from Ventura County Behavioral Health to address the Latino/a penetration rate as well as other issues raised in their report.

LULAC REPORT MAJOR THEMES (Excerpts Quoted)	COUNTY RESPONSE
LULAC characterizes the inquiry leading to the publishing of their November 1, 2014 report as collaborative.	In the spirit of transparency, since August 2014, LULAC has been provided unprecedented access to interview VCBH staff, review data, and collect relevant materials. The report was distributed via email and was provided to the MHSA State Oversight and Accountability Commission (OAC), during public comment at a community forum held on November 6, 2014 at the Crown Plaza Hotel in Ventura, where there were approximately 250 in attendance. There have been subsequent revisions, with at least one disseminated to the public on January 3, 2015.
"Employees from the Behavioral Health Agency were interviewed to obtain their thoughts and perceptions regarding the equitable and/or inequitable distribution of Behavioral Health services and resources to the Latina/a community." (pg.5)	Some VCBH employees, interviewed by LULAC and listed as participants in interviews for this report, have stated that in agreeing to be named as a participant, their assumption was that their opinions and the information they provided would be represented in the final report, which they state was not the case.
Regarding the Latino Medi-Cal Beneficiary Penetration Rate and VCBH's Performance Improvement Outcomes LULAC finds Ventura County's penetration rate to be "unsatisfactory" (pg.10). "The penetration rate for Latino/as in Ventura County is 2.94% . . ." (pg.10)	VCBH agrees that the Latino Medi-Cal beneficiary rate is an area for continued performance improvement. It is clear that VCBH's Latino Medi-Cal penetration rate has improved measurably over time as is shown in the graphs below. LULAC cites 2012 data, when the more current 2013 data was available, showing a penetration rate of 3.46%, which compares more favorably to the large county average (3.67%). 3.46% represents a 14.6% increase in the rate from the prior year (which was actually 3.02%, not 2.94% per a supplemental report published in January 2014). During the same time period the Statewide average increased 2.9%, and the Large County Average increased only 1.1% - which is evidence of VCBH's efforts. See the graph below for 8-year trend.

On Jan 3, 2015 LULAC states, "A more recent review of the above APS Healthcare data showed a slight increase in some of the noted areas. For example, the MHP (VCBH) penetration rate for "Hispanic beneficiaries" in June of 2014 was 3.92% and 13% less than the statewide average. "

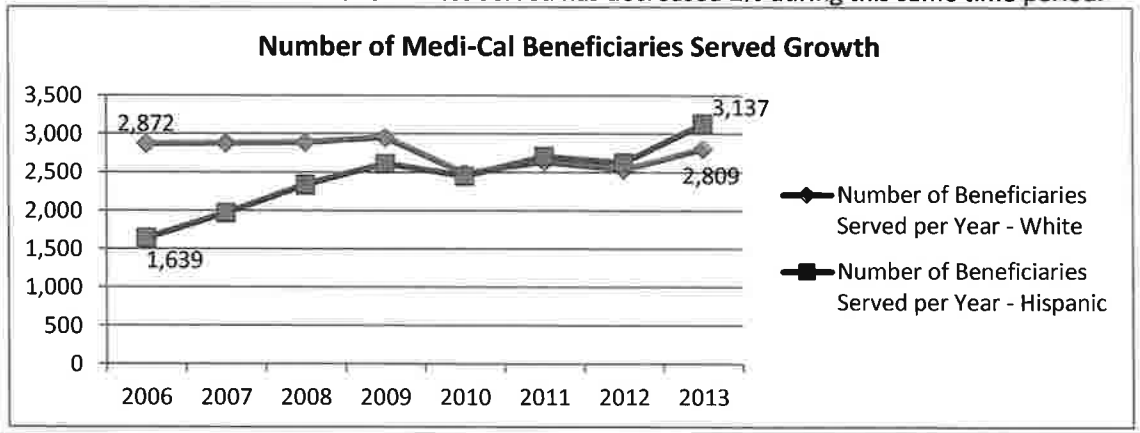
"A view of all pertinent reports . . . all validates the observation that VCBH has been advised and cited repeatedly for not doing a satisfactory job of responding to the mental health needs of the Latina/a community in the same manner that it responds to the White and more affluent sector of the county. " (pg.10)

Penetration rates for 2014 have not been published. Please note that prevalence rates also need to be taken into consideration for an accurate analysis of how Ventura county is performing in relation to other counties.



From Calendar Year 2010 State Report: "Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs [Counties]"

According to APS Data 2006 to 2013, Ventura County's Latino penetration rate increased +63%, while the white penetration rate decreased -16%. The actual number of Latinos served has increased 91% and the number of whites served has decreased 2% during this same time period.



	While state data indicates that the majority of Latinos do not return for continued treatment after the first visit, this is not true for VCBH, where a comparison of FY 13/14 Latino and White retention rates show retention rates slightly better for Latinos at 4+ visits (80.3% vs. 76.9%). The LULAC report does not address retention, which is an important aspect of analysis in reviewing mental health treatment services for underserved populations. Also not mentioned in the report, is the fact that disparity in Latino access to mental health services is a national and state-wide challenge: http://www.ucdmc.ucdavis.edu/newsroom/pdf/Latino_mental_health_report-6-25-2012-1.pdf http://www.cnn.com/2013/10/09/health/latino-mental-health-disparities/ One of the primary reasons for disparity is stigma, which VCBH has been addressing both in its support of state-wide projects and through local efforts. Statewide projects: http://calmhsa.org/programs/cultural-responsiveness/crdp-california-reducing-disparities-project/
"Our interview of leaders from the African-American community revealed that they too share the same concerns expressed by Latino/a community leaders regarding inadequate mental services support to their community." (pg.10)	Ventura County's penetration rate for African Americans is higher than the state average for like-size counties. This data was available at the time of the report. 2012 VCBH African American Penetration Rate: 11.93% (state average large counties per APS 9.77%) 2013 VCBH African American Penetration Rate: 11.36% (statewide for large counties per APS 9.42%) Both years' penetration rates for African Americans are higher than the penetration rate for the white population in Ventura County.
"LULAC's interview of executive level VCBH managers found that there is an uncorroborated belief among this unit that there are other mental health services providers in the county, such as Clinicas del Camino Real, that also serve the SMI Latino/a population and that therefore the Holtzer [sic] data and corresponding VCBH services do not represent the complete picture, implying that Latino/as are receiving SMI services elsewhere." (pg.18)	In FY 11-12, APS recommended that VCBH devise a mechanism for tracking beneficiaries served in conjunction with local FQHC's in order to capture improved accuracy in penetration rate reporting. This recommendation sparked VCBH's interest in Clinicas' mental health service data, so that a more complete picture of how we are doing collectively in Ventura County to serve the Latino population might be achieved. The fact that Clinicas serves SMI/SED clients is substantiated by public comment made at the Behavioral Health Advisory Board on 3.17.14: *"Ms. Campos Juarez, the Director of Mental Health Services at Clinicas del Camino Real advised the board of an emerging concern. She stated that Clinicas currently provides treatment for individuals with Serious Mental Illness and that depending on a pending decision by the state, those clients may need to be transferred to county mental health. The state is evidently considering whether or not to enforce the January I, 2014 start date to*

	the new policy. Ms. Campos Juarez commented that this change in service will disrupt the treatment of patients who currently receive integrated care at Clinicas."
"LULAC made a direct inquiry into the noted belief and found that (a) the number of SMIs served by Clinicas is not significant when measured within the context of the overall statistical scenario, and (2) pursuant to state mental health guidelines, . . .	Clinicas' data, as reported on the federal website for Health and Human Services, indicates that it provided mental health services for 3,529 individuals in 2013. http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=093650&state=CA&year=2013 While it is unclear how many seriously mentally ill Latino adults or seriously emotionally disturbed Latino youth Clinicas serves, it is likely that the majority of youth served would meet EPSDT criteria. Therefore it is likely that the numbers of individuals served by Clinicas is material to a comprehensive understanding of mental health service delivery to the Latino population in Ventura County.
. . . only the VCBH is supposed to be serving the SMI population and therefore the sole responsibility for the disparate findings is with the VCBH." (pg. 18)	During the time period referenced in the LULAC report, the sole responsibility to treat SMI did not rest with VCBH, which is why APS suggested that FQHC data be shared and reviewed county-wide.
On page 17, LULAC writes, "this inquiry included an examination of serious mental illness (SMI) prevalence rates which required a review of the literature pertaining to Charles Holtzer [sic]. . ."	VCBH disagrees with the manner in which LULAC interprets and presents Holzer data, however is willing to engage in dialogue regarding its analysis and use by the Department. The LULAC report does not compare Ventura County Holzer data to other counties, similarly challenged in providing services for individuals, who are not covered by Medi-Cal and for whom there is no other payor source.

Year	County	Served	Holzer Target	% Difference
10-11/11-12	San Bernardino	8,188/8,781	36,817/36,817	-77.76%/-76.15%
10/11/11-12	San Diego	9,974/10,734	38,314/38,314	-73.97%/-71.98%
10-11/11-12	Fresno	4,827/4,904	22,539/22,539	-78.58%/-78.24%
10-11/11-12	Ventura	2,451/2,709	10,422/10,422	-76.48%/-74.01%

Per VCBH QI, '11/12 is most current information available.

Consistent with Ventura County and Health Care Agency policy, VCBH provides service to individuals meeting specialty mental health criteria without regard to insurance or immigration status.

"He (Mr. Powers) cited the founding of the MICOP organization in Ventura Count as one example of the support that the County has exerted to serve this community. LULAC advised Mr. Powers that the findings from our investigation clearly showed that this population is not being adequately served and there is much that needs to be done to address this deficiency." (pg. 20)	VCBH agrees that the Mixteco population is underserved, related to mental health treatment, and has responded by supporting programs for a number of years that both outreach and provide support to this population. With the opening of a new clinic in South Oxnard at the Center Point Mall and through a partnership with the Mixteco/ Indigena Community Organizing Project (MICOP), VCBH intends to continue the Health Care Agency's long standing partnership with MICOP, to implement services and supports that will improve access and treatment services for this population. Additionally, a VCBH contracted provider, Turning Point Foundation, who operates the VCBH Adult Wellness and Recovery Center (AWRC) in Oxnard, has hired a Mixteco-speaking individual to assist with engagement, in addition to offering space for MICOP to conduct groups and meetings.
VCBH's Responsiveness to APS Recommendations. "Noted in the reports was the consistent failure of the VCBH to achieve any progress in addressing the APSH recommendations for corrective action. The repeated observations and subsequent recommendations all point to the failure and refusal of VCBH to effectively address the mental health needs of the Mexican population of Ventura County in an equitable manner as compared to the White population of the county." (pg. 9)	Every year APS makes "Key Recommendations" and in a review of reports dating back to '06, all forty (40) key recommendations were either "fully addressed" or "partially addressed", with the following two exceptions: *06-07: Maintain steady progress toward a HIPAA compliant Medi-Cal claim.* This is the only recommendation scored as "not addressed" in any APS report. VCBH was unable to address this recommendation until it contracted with Netsmart in 2007 for a new management information system, which allowed VCBH to produce compliant Medi-Cal claims. *11-12: Devise a mechanism for tracking beneficiaries served in conjunction with local FQHC's in order to capture improved accuracy in Penetration Rate reporting.* This recommendation has not been achieved, because VCBH does not have access to Clinicas' data. Interestingly, with just an additional 192/418 SMI/SED clients accounted for in 2013, Ventura County would have achieved the large county/state penetration rate of 3.67%.
"Based on the majority of the interviews conducted, it was our conclusion that the recommendations were and continue to be ignored by the VCBH management team." (pg. 12)	In the FY1314 EQRO Report by APS, conducted on 11/14/13: Ventura County was identified as one of the 15 Mental Health Plans (MHPs) in the state with the "highest total performance in the Key Components, organized by quality, access, timeliness, and outcomes."

"In terms of service to the Latino/a community, a summary characterization of the APS Healthcare evaluation reports for the Ventura County Behavioral health (VCBH) operation over the noted period amounts to what can be best described as a "broken record" repeating the same recommendations year-after-year." (pg. 9) LULAC notes the following as "just several of the recurring recommendations issued by APS Healthcare." (pg. 12)	Of the approximate forty (40) Key Recommendations, there are seven (7) repeated since 2006-7. Of the seven (7), some are ongoing goals and some were by design, multi-year projects. The implementation of an Electronic Health Record is an example of an ongoing project. Another example of an ongoing project is to *(12-13) Expand bilingual/bicultural and overall psychiatry capacity by recruiting and deploying additional professional staff with similar scopes of practice such as Nurse Practitioners or Physicians Assistants or by using tele-psychiatry service.* Providing medication management in the Spanish language has been a challenge, although VCBH has worked on this consistently by: offering higher rates and incentives for bilingual psychiatry (3 contracted, 1 offer pending); hiring a bilingual nurse practitioner; and the implementation of bilingual tele-psychiatry. It is reasonable to expect this to be an ongoing, multi-year goal, given that there is a national shortage of bilingual psychiatrists.
3.A The need for VCBH to examine and consult with other agencies that are being effective in serving the Latino/a community to "to mitigate this ongoing disparity. [Access, Quality]" (pg.12)	This recommendation appeared for the first time in the 2013-14 report. VCBH took this recommendation to heart and facilitated a series of 12+ community meetings involving key stakeholders from the Latino community, so as to gather local data regarding how to improve both outreach and treatment services.
3.B Examine and correct the failure of the agency to effectively follow-up with patients after hospitalization. (pg.12)	This area has been a challenge, and became the subject of a performance improvement project (PIP), with the support of the County CEO's office. The responsibility of ensuring that people who meet specialty criteria are warmly handed off to ongoing outpatient mental health services is a shared responsibility between VCBH and VCMC's Inpatient Psychiatric Unit. The PIP was completed and data is jointly being collected. As additional testimony to the County's commitment to improve follow up with patients after hospitalization, was the inclusion of staff to facilitate linkage to outpatient post-hospitalization in the VCBH SB 82 grant application. With the highest score in its region, VCBH acquired $7.5M in funding to establish a program to assist in engaging hard to reach clients, including the homeless and those transitioning from acute to outpatient care.
3.C Continue to analyze and correct the excessive level of denied Medi-Cal claims, attributed to faulty MIS system. (pg.12)	The claims issue is not due to a faulty MIS system. As with many counties with the implementation of Short-Doyle II, Ventura experienced issues reconciling paid claims with the state. Our most recent analysis of billed vs. paid units for Medi-Cal indicates a denial rate at approximately 4%, less than the 2012 state average (both historical and current claims data was never requested by LULAC at the time of the report).

	County mental health penetration rate data is based on "claims data, meaning billed services as distinct from delivered services. As described above, due to reconciliation issues with the state, Ventura County's penetration rate data was affected. In a January 27, 2014 email to the VCBH Chief Operations Officer, a Quality Improvement manager writes, "I had no idea that the error rate for claims submissions was 11% until I saw the EQRO draft. That is completely unacceptable."
3.D Continue efforts to expand bilingual-bicultural and overall psychiatry capacity by conducting an analysis of the existing service need gap and then implementing strategies to address findings. (pg. 12)	APS recognized this as partially addressed. The expansion of this capacity is a continued area of focused improvement for VCBH.
VCBH's Transparency as related to sharing data with APS, the public, and Senior County Officials.	
"APS Healthcare audit reports for the past six years, from 2007 to 2013, were also obtained, read, and analyzed. Reportedly, these reports were never shared with senior County officials or the public." (pg.4) "According to senior VCBH personnel interviewed by LULAC, it is the policy of Assistant Health Care Agency Director Meloney Roy and her lead managers to not share most reports such as the ones completed by APS Healthcare with upper managers, including the Director of the Health Care Agency." (pg.9)	EQRO site visits are not audits, but are conducted in the spirit of consultation, feedback and quality improvement. VCBH did in fact share EQRO reports with Michael Powers (County CEO), when he was the HCA Director and with Dr. Robert Gonzalez, former HCA Director. At VCBH Director, Meloney Roy's request, Dr. Gonzales attended APS site review feedback meetings on at least two occasions. APS site visits, during which VCBH penetration rate data was discussed, were attended by VCBH staff, HCA Executive Team Members, BHAB members and others from the community. APS EQRO reports were also available online for public review on the APS website, which was announced at the entrance meeting with APS.
"On September 10, 2014, LULAC sent an email communication to Ms. Meloney Roy asking for guidance as to where on the VCBH website the public can view the APS Healthcare reports or the VCBH Annual Summary reports. Ms. Roy responded in writing to inform LULAC that it is	Ms. Roy's response to the referenced email was as follows: "The EQRO documents you reference are not normally posted for public view by us or any other county mental health department to the best of my knowledge. Final EQRO reports were however customarily posted by APS on their own website."

not the practice of this County agency to post this type of information for public view." (pg.10)	
"The matter at hand, the perceived shrouding of data, is perhaps the most egregious finding uncovered by this investigation. There is a widespread perception that there is strong resistance within VCBH by senior management to using evidence (data) to guide planning and allocation of resources to the community."(pg.16)	VCBH shares data in many public forums. Local Mental Health Program data (operations and fiscal) is reviewed regularly by: the Behavioral Health Advisory Board (BHAB) – monthly; Behavioral Health Exec/Budget Committee – monthly; Age-specific Subcommittees of the BHAB – monthly; and Community Leadership Committee – quarterly – all in public meetings (Brown Act), with posted agendas/minutes. Just two examples: 1) The following information resulted from a comprehensive review of MHSA programs conducted in 2013, which was presented at a series of stakeholder meetings, during which there was extensive public input. The long-standing goal of the department is to ensure that the community is able to make fully informed decisions regarding MHSA programming. **http://www.vchca.org/docs/behavioral-health/css-summary-of-program-presentations.pdf?sfvrsn=0** 2) In 2014, the department with members of the Behavioral Health Advisory Board (BHAB) and the Community Leadership Committee (CLC) conducted a comprehensive review of Community Services and Supports (MHSA funded) contractors to ensure that the appropriate performance and outcome measures are in place. There were over 20 meetings, with resulting recommendations to improve efficiencies and cost effectiveness, which were implemented by the Department.
"When asked about the motive for not sharing such reports or findings with senior administrators, one VCBH staff member stated to LULAC that "the managers spend a lot of time covering up anything that might make them look bad with the higher ups or the Board of Supervisors." (pg.9)	In addition to other numerous public presentations of VCBH data, on February 14, 2014 a presentation was made to Supervisor Zaragoza and interested Latino community leaders, during which data related to the challenges VCBH faces in increasing the numbers of Latinos accessing service was discussed and a power point presented .
"One Quality Assurance staff member informed LULAC that the APS Healthcare organization was usually treated in an adversarial manner by senior VCBH managers "In the ideal world, our	LULAC does not provide any hard evidence to support its claims related to VCBH's treatment of and relationship with APS. In fact, an email complimentary to the relationship between VCBH and APS was sent by one of the APS site reviewers to Meloney Roy and two Quality Assurance managers. Quoted from the email, "I wanted to take a moment to personally thank you for the time we've

agency would have looked at the APS recommendations as an opportunity to improve services but they were really not welcome here. For example, APS would usually contact us each year a couple of months in advance of their visit to get some up-front information from us. I was usually told by Meloney's people to stall giving them what they asked for, just to make things hard on them and so they would not be well prepared when they got here." (pg.9)	spent working together in the past several years through the EQRO process. I have thoroughly enjoyed working with each of you and have appreciated the warm reception you've always extended to me." VCBH Administration and other Quality Assurance staff emphatically deny that staff was ever instructed to stall reporting to APS. That fact that VCBH administrators supported timely reporting to APS is evidenced by over 20 emails between administrators and Quality Assurance staff.
Later in the report, LULAC accuses VCBH's managers of directing Child Welfare Subsystem staff to withhold information from federal compliance officer – referenced later as the "Katie A Incident".	The nature of the Katie A. Special Master's visit to Ventura County was collaborative. He was invited to Ventura County through collaborative planning between BHD and HSA. This was not an audit, but rather an opportunity to share the design, implementation, successes and challenges of the joint efforts between VCBH and HSA to restructure the delivery of mental health services within the foster care system.
VCBH's efforts to addressing barriers to access and effective treatment for Latino consumers: <u>*Linguistic Needs*</u> "Lead administrators from VCBH are highly resistant to providing Spanish-speaking clients with the appropriate linguistic support required for them to benefit from treatment and/or services in a manner equitable to English-speaking clients receive from the agency. (pg.11)	To the contrary, VCBH has made significant progress in increasing linguistic capacity on behalf of monolingual Spanish-speaking and limited English proficient (LEP) consumers. • Increased bilingual rate for psychiatrists, in order to retain/attract bilingual psychiatrists (3 contracted, 1 in process). • Added 1 bilingual nurse practitioner • Bilingual tele-psychiatry implementation • Language Performance Improvement Project – Development of a Spanish language Master Treatment Plan. • Establish bilingual internship program, with stipend incentives ("grow our own" approach), which has encouraged bilingual interns to choose BH as their learning site. As of this year, we now have a total of 60 interns, 50% of which are bilingual. In the UC Davis reducing disparities report, "the participants also highlighted the need to "grow our own" mental health providers"

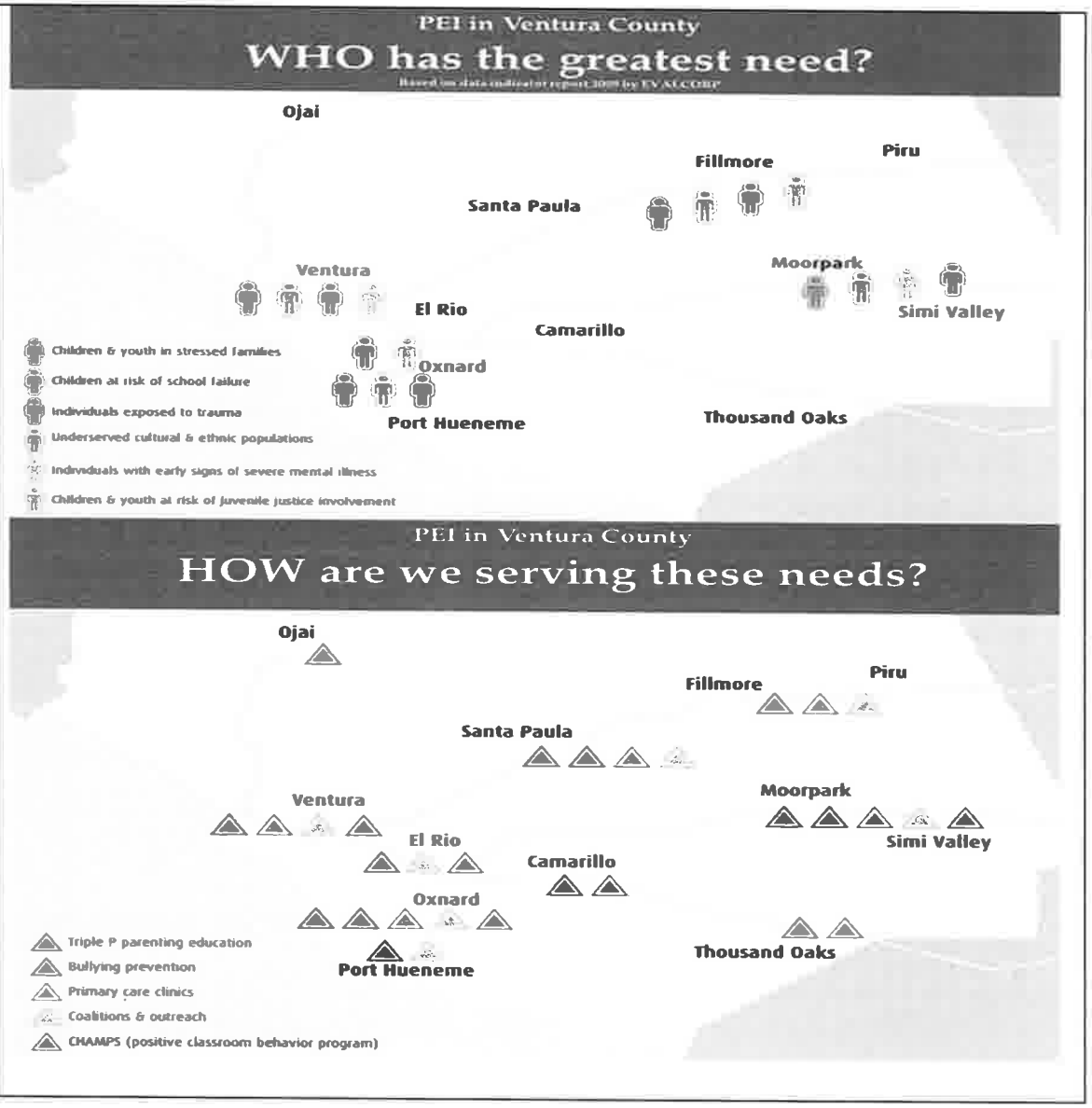
	http://www.ucdmc.ucdavis.edu/newsroom/pdf/latino_disparities.pdf page 26. This is exactly what VCBH is working to do. 49 students have been hired, of which 31 are bilingual (63%). Bilingual - Spanish/English Students FY 5/6: 1 FY 6/7: 4 FY 7/8: 3 FY 8/9: 4 FY 9/10: 6 FY 10/11: 8 FY 11/12: 4 FY 12/13: 20 FY 13/14: 25 FY 14/15: 31 *Note: Bilingual Stipends fully implemented in FY 12/13* VCBH also funded a trilingual program three evenings a week at Turning Point Wellness and Recovery Center, located in South Oxnard. Staff includes a trilingual Spanish/Mixteco/English speaking lead and three bilingual Spanish speaking Peer Specialists. This staff is in addition to the 70% Spanish-speaking staff in day time. VCBH has made significant strides in increasing the number of bilingual staff. As of Jan 2015, there are a total 119 bilingual mental health staff, which represents a 32% growth from 90 as of 2009. Absent a bilingual mental health professional, an interpreter is necessary. http://mcr.sagepub.com/content/62/3/255.short VBCH's policy (Use of Interpreters CA 48), includes the statement that language interpretation services should occur within 30 minutes for LEP clients who need language assistance.
Overcoming barriers related to lacking transportation: LULAC received conflicting information related to whether or not VCBH is sensitive to the challenges for consumers lacking adequate transportation. Nevertheless "insensitivity to travel and access to services" (pg. 27) was listed as a finding.	VCBH regrets that there are instances when lacking transportation impedes a consumer's ability to access necessary services. To mitigate the reality of inadequate public transit in certain areas of the county, VCBH has contracted with a transportation company to provide rides to treatment (over 5,000 rides provided in Oxnard alone). In 2007 and 2008 VCBH purchased 14 vehicles to transport consumers to appointments, labs, and other activities. A new clinic for Oxnard was established at the Center Point Mall to enhance access for consumers and family members living in South Oxnard/Port Hueneme. The VCBH evaluation team, STAR, travels county-wide as does the VCBH crisis team. The recently implemented Rapid Integrated Support and Engagement (RISE) program, funded by an SB 82 grant, provides field-based evaluations for hard-to-engage consumers.

<u>Providing Culturally Competent Services</u> LULAC identifies cultural incompetence as a finding.	VCBH was the champion of a cultural competency training project supported by the Southern California Regional Workforce Education and Training Partnership, whereby Dr. Steven Lopez of USC was funded to do cultural competency training for 4 counties and study its efficacy. VCBH provides ongoing training for its staff and embraces the importance of providing services and supports that are sensitive and responsive to culture – all cultures. The LULAC report however, illuminated some philosophical differences in how cultural competency is defined, supported and measured within an organization. In order to generate consensus with advocacy groups such as LULAC, and so that the Department may move positively forward in collaboration with its stakeholders on initiatives to address disparities in mental health care, there needs to be a shared definition of what it means for an organization and its staff to be "culturally competent." Therefore, the VCBH Office of Health Equity has been tasked to work with stakeholders to devise a working definition of cultural competency that utilizes current research and identifies and implements a validated cultural competency tool that may be used to monitor both county and contracted programs and services.
VCBH's Resourcing (Staffing and Financial) in support of services to the Latino population. "This section of the report is focused on what we perceive to be the systemic practice of not funding Latino operated programs and/or culturally competent programs in a fair and equitable manner, as compared to programs owned and/or operated by members of the White community." (pg.22)	To choose contractors, with regard to their ethnicity, as LULAC suggests, is illegal. Linguistic capacity, cultural sensitivity, clinical expertise, experience, financial stability, etc. are all taken into consideration when a contractor is chosen.
"As offensive as this term and its definition may be to some readers. . .it (Poverty Pimping) was used within the context of this report to describe the practice of using the Mexican demographic to justify and acquire public funding and then	VCBH's MHSA Prevention and Early Intervention (PEI) Plan was developed using data to identify the geographic areas of need in the county. Through focus groups and key informants, the community identified their specific needs and strategies that might best identify those needs. VCBH implemented programs in the identified, underserved geographic areas of Ventura County following the recommendations made by key informants of those underserved communities.

diverting the bulk of those resources to other, more affluent White communities that by themselves would never have qualified for the received funding due to lack of demonstrated need." (pg. 7)

One elected official stated to our investigator "We are sick and tired of watching agencies like this [VCBH] use our people to justify getting money and then making sure that very little of it is shared with the people who really want to do something for our community. It's like the old Indian reservation thing where the agents would receive supplies for the people but the food never made it to the people." (pg. 22)

If you look at their budget and where all of the money goes, you'll see that almost none of it is used to serve Latinos the way they serve people in places like Simi Valley or Thousand Oaks.



	Contrary to what LULAC reports, a review of implemented PEI programming reveals that the programs were implemented in the identified geographic areas, addressing the needs of the community. Below is a link to the PEI Evaluation Report: http://www.vchca.org/docs/behavioral-health/fy-13-14-update---pei.pdf?sfvrsn=0 In addition to Prevention Early Intervention funding, another major source of VCBH funding is Medi-Cal. Medi-Cal funding is based on services delivered, through which federal dollars are drawn down. The race or ethnicity of the person being served has no bearing on the amount of revenue generated. MHSA funding allocations to counties are based on the following: 50% county population; 30% population likely to apply for services, which is the sum of poverty population (<200% federal poverty level) and uninsured with incomes above 200% of federal poverty level; 20% population most likely to access services, which is based on the prevalence of mental illness among different age groups and ethnic groups in each county. VCBH does not control how the state allocates MHSA funding.
One of the most salient complaints that LULAC received from VCBH staff was the perceived disparate treatment of clinical staff (and by extension the client population) in terms of staff ratio to client population. According to one manager interviewed, "if you go the Adult Service Center in Simi Valley or Thousand Oaks you will see a plush, modem facility with a lot of staff. You will not see what you see in Oxnard." (pg.25) LULAC contends throughout the report that VCBH does not its contractors accountable and does not fund programs in a cost-effective manner. "A lot of these programs do almost	Actual staffing levels demonstrate that the majority of staff is located in the West County, not East County. "Salaries and benefits" is the largest line item in the VCBH budget, meaning that VCBH allocates the majority of its resources to the West County. The Oxnard clinic at Williams Drive is a modern facility. VCBH just completed a significant investment ($2M) in a new south Oxnard clinic, for which there was a grand opening on December 10, 2014. This clinic is co-located with the HCA Medi-Cal Clinic, Las Islas and the Turning Point Wellness and Recovery Center. It is anticipated that new staff will be hired to accommodate the increased numbers of clients accessing care. VCBH holds its contractors to high standards and is constantly supporting performance improvement related to data collection, monitoring and decision-making. Treatment contracts are monitored in a team approach, with representation of the following areas: operations, Quality Assurance, finance and contracts' management. Contract monitoring meetings occur with the contractor and the monitoring team to review financial, outcome, performance and other data.

nothing and they get millions of dollars." (pg. 24)	When issues are identified, or contract expectations are not being met, plans of correction are put into place and monitored. Additionally, all MHSA programs have been reviewed in the Behavioral Health Advisory Board (BHAB) and Community Leadership Committee (CLC) meetings which are governed by the Brown Act.
"For example, if a program received $1 million to train individuals to provide a certain service and you trained 22 people during the funded period, the cost to train each person was $45,455. A second question that would be asked would be "Of the total number of people trained, how many obtained employment using the skills that they learned in your program?" If that number is 14, then the actual cost of training and placing each person in a training related job was $71,428.57. The final question would be, "How reasonable was the cost to our agency and to the taxpayers?" (pg.8)	While this paragraph is presented as hypothetical scenario, it's similarity to a VCBH funded program, Recovery Innovations (RI), is so close that the reality of RI's budget warrants clarification. What LULAC fails to reveal is that of the $1.3M budget, approximately $900K is spent on peer salaries for approximately 38 employed mentally ill individuals (24 FTEs of which 6 bilingual). In addition Recovery Innovations peer staff then provides approximately 1200 people with WRAP and WELL classes. These peers are providing direct services to clients, utilizing their lived-experience. Utilizing peers is a requirement of MHSA and hiring through Recovery Innovations is cost effective.
LULAC proposes a number of recommendations to address its findings.	VCBH looks forward to reviewing the report with LULAC, to come to a mutual understanding regarding the current status of VCBH outreach, programming and performance/outcome data related to the Latino population. From that understanding, it is hoped the VCBH and LULAC will work collaboratively in the future to promote wellness and recovery for SMI/SED Latino consumers, youth and family members.

February 23, 2015

To: Mr. Kevin Hoffman, MHSOAC
From: JCDr. Jaime Casillas, Chief Civil Rights Investigator, LULAC California
Subj: County of Ventura response to LULAC investigation
Copies: Stacie Hiramoto, Elaine Crandall, Barry Fisher, Dave Rodriguez, Michael Powers

Our organization received a copy of the County of Ventura's Behavioral Health (VCBH) agency written response to our investigative report. In addition, we received a copy of the report that your office prepared for members of the Mental Health Services Oversight and Accountability Commission.

Mr. Hoffman, our interpretation of the VCBH written response to our investigation, in our mind, represents (a) what the previous VCBH administration had to say about the matter; please be reminded that at the present time we have in place a relatively new Health Care Agency Director, Barry Fisher, and a new Behavioral Health Director, Elaine Crandall. In addition, (b) it is our view that the content of the rebuttal was not based in reality and represents the requirement that County administrators hold the line in terms of performing their due diligence of doing and saying whatever it takes to preserve and protect their area of responsibility. In effect, you have to agree that there is probably not a single county agency in this state or across the nation that would have ever embraced the embarrassing and pathetic description of malperformance that was included in our report. We stand by our findings and we believe that any intelligent, honest person or organization prepared to re-trace our steps would make the same conclusions that we made. We are not concerned about what was stated in the rebuttal and the political posturing that County administrators are required to take when dealing with public relations requirements. More importantly, we are interested in the VCBH's response to our recommendations which thus far has been very encouraging. Senior county VCBH staff has made a seemingly genuine commitment towards implementing the recommendations that we included in our report. Most notably, they have agreed to establish a Disparities Reduction Committee that will include membership of stakeholders from the Latino/a community. This committee will be integrated into the already existent structure of the VCBH committee process and will have as it main charge that of advocating and helping to reduce disparities.

In your briefing report to members of the oversight commission, you (or others from your office) stated the following:

"To be clear, based solely on reading the LULAC report, there is no way to determine or analyze whether various findings and observations in the report about service and fiscal

disparities to the Latino/a community in Ventura County are accurate. As such, what follows is a summary of the observations and findings as described in the LULAC report."

We fully understand the need for VCBH administrators to avert any claim or admittance to the findings that we listed in our report but our organization is puzzled as to the apparent aversion on the part of your office. When you state that "there is no way to determine or analyze whether various findings and observations in the report about service and fiscal disparities to the Latino/a community are accurate," our interpretation of what was stated is that you and Commissioners to not have access to the APS Healthcare reports for the past six years or that you do not have access to data regarding the penetration rate in Ventura County of any other county. To be clear, LULAC based its findings on what was stated in said reports and what was reported to us by VCBH administrative staff. Therefore, when it is stated that there is no way to verify what we reported, the logical conclusion is that MHSOAC does not have the capacity to access the same information that was provided to LULAC. Surely your office has access to the performance data of behavioral health agencies across the state. In the spirit of your view that the findings in our report cannot be verified as accurate, I would like to, in turn, offer a more realistic viewpoint: consistent with the perspective of the Little Hoover Commission, county agencies cannot prove that they have measurable results to account for the hundreds of millions of dollars that they squander or mismanage every year and they are allowed to do so because oversight bodies, like the MHSOAC, are irresponsive or lack the capacity to hold counties accountable.

In summary, the VCBH rebuttal, in unison with the statement that I quoted from your report, give credence to the position of the Little Hoover Commission in its January 27, 2015 report in which it characterizes the nature of the County BH agencies and MHSOAC as follows:

"In this review, the Commission learned that funding provided by Proposition 63 – now more than $1 billion annually and representing about 25 percent of California's overall mental health spending – continues to evade effective evaluation due to antiquated state technology and overlapping and sometimes unaccountable bureaucracies. The Legislature appropriately empowered the Mental Health Services Oversight and Accountability Commission by making it independent, but it still lacks teeth and shares oversight responsibilities for the act with the Department of Health Care Services. The Legislature should expand the authority of the oversight commission. Specifically, it should have the authority to conduct up-front reviews of the more controversial preventive programs funded by the act and be empowered to impose sanctions if counties misspend funds from the act or fail to file timely reports with the state."

As LULAC stated to you and others, our organization is moving forward with a restrained but moderate measure of new found optimism that the new administration at VCBH will make a good faith effort to address the recommendations that were included in our report. In a recent meeting with Mr. Crandall and Mr. Fisher, there was displayed what we considered to be a genuine attempt on their part to respect the findings of LULAC and to establish a process of shared governance that will now include direct representation from the Latino/a community that has thus far not had a place at the table with the previous VCBH administration.

AGENDA ITEM 6A

Information

March 26, 2015 Commission Meeting

Little Hoover Commission Round Table Discussion

Summary: During the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) meeting on February 26, 2015, the Commission heard a presentation on the Little Hoover Commission (LHC) report released in January, 2015 entitled, *Promises Still to Keep: A Decade of the Mental Health Services Act*. The report includes recommendations regarding MHSOAC authority. The Commission has put together a panel of Subject Matter Experts to discuss issues related to these recommendations and to provide further recommendations to assist the Commission. The Commission is forming a task force to follow up on the issues raised by the panel and the LHC. This panel discussion is a result of the Commission's request at the February 26, 2015 Commission Meeting. The panel will be split into two panels in order to better facilitate the conversation.

The report can be found at the following web address: http://www.lhc.ca.gov/studies/225/Report225.pdf.

Panel A: The perspective of Department of Healthcare Services, service providers, and the County Behavioral Health Directors Association/Counties.

- Karen Baylor, PhD, LMFT
  Deputy Director
  Mental Health and Substance Use Disorder Services
  Department of Health Care Services

- Rusty Selix
  Executive Director
  Mental Health America of California

- Adrienne Shilton
  Director, Intergovernmental Affairs
  County Behavioral Health Directors Association of California

Panel B: The perspective of clients, consumers, family members, advocates for children and families, and unserved and underserved communities.

- Jessica Cruz (Invited)
  Executive Director
  National Alliance for the Mentally Ill (NAMI) California

- Sally Zinman
  Executive Director
  California Association of Mental Health Peer Run Organizations (CAMPRO)

- Nicki King, Ph.D.
  Director
  California Reducing Disparities Project (CRDP)

- Reverend Dr. Oscar Wright (Invited)
  CEO
  United Advocates for Children and Families (UACF)

Enclosures: MHSOAC Staff Overview of the Little Hoover Commission Report on Proposition 63, "Promises Still to Keep: A Decade of the Mental Health Services Act."

Handout: None

Recommended Action: A summary of the panel discussion will be provided to the task force composed of MHSOAC Committee members for further consideration. Final recommendations will be heard at a future Commission meeting.

Presenter: Toby Ewing, Executive Director, Mental Health Services Oversight and Accountability Commission.

Motion: None at this time. A summary of the panel discussion will be provided to the committee member task force for further consideration.

MHSOAC Staff Overview
Of The Little Hoover Commission Report on Proposition 63, "Promises Still To Keep: A Decade of the Mental Health Services Act"

Introduction

On January 28, 2015, the Little Hoover Commission (LHC) released a report to the Governor and the Legislature entitled, *Promises to Keep: A Decade of the Mental Health Services Act*. The report – an assessment of the Mental Health Services Act (MHSA) – is part of LHC's broader review of California's initiative process, with particular focus on the Legislature's role in clarifying or modifying a voter-approved initiative. The Mental Health Services Oversight and Accountability Commission (MHSOAC), Department of Healthcare Services (DHCS), California Behavioral Health Directors Association (CBHDA) representatives, and representatives of various stakeholder groups provided written and verbal testimony September 23, 2014. The report summarizes what LHC learned about the MHSA through its study and concludes with recommendations, all of which are highly relevant to the MHSOAC. The report can be found at the following web address: http://www.lhc.ca.gov/studies/225/Report225.pdf

LHC Report Recommendations

The following are the report's recommendations:

1. *MHSOAC Authority:* The Legislature should expand the authority of the Mental Health Services Oversight and Accountability Commission.
    a. Require the oversight commission to review and approve county Prevention and Early Intervention plans annually, as it currently does for Innovation plans.
    b. Refine the process by which the state responds to critical issues identified in county three-year plans or annual updates to ensure swift action. Empower the oversight commission to impose sanctions, including the ability to withhold part of the county's MHSA funds, if and when it identifies deficiencies in a county's spending plan. Decisions of the oversight commission should become mandatory unless they are overturned by the Department of Health Care Services within a reasonable period, such as 60 days.
2. *MHSOAC Authority:* To provide greater oversight and evaluation of the state administrative funds, the oversight commission should annually develop recommendations for and consult with the Department of Finance before the funds are allocated.
3. *Transparency and Accountability:* The MHSOAC should add to and update material on its website to include:
    a. MHSA revenues by component and annual allocations, and the cumulative total revenue since voters approved the act.
    b. Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.
    c. Data to demonstrate statewide trends on key indicators such as rates of homelessness and suicide that show how well the act's programs help those living with mental illness to function independently and successfully.

d. All county MHSA plans and reports submitted to the state, including MHSA annual revenue and expenditure reports, Three-year program, and expenditure plans and annual updates, other relevant reports such as county cultural competence plans.

4. *Access to Timely, Reliable Information to Monitor Progress toward MHSA Goals*: MHSOAC and DHCS should:
    a. Immediately develop a formal plan and timeline to implement a comprehensive, statewide data collection system capable of incorporating data for all MHSA components, as well as other state and behavioral health programs.
        i. Plan should address funding for data collection system
        ii. Should use a portion of MHSA state administrative fund to support the effort
    b. Regularly report to the Legislature on progress made in developing data system and identify challenges that arise.

In addition to analysis and recommendations, the LHC report addresses:

- History of the November 2004 passage of Proposition 63 including high expectations generated
- MHSA implementation, including changes that have occurred through legislative actions
- Summary of MHSA components
- The MHSA's changing contribution to financing California's public mental health system
- Enumeration of the entities that receive MHSA administrative funds
- Delineation of roles and contributions of various entities to MHSA implementation and oversight

This summary provides an overview of the LHC report and of current MHSOAC activities that are relevant to LHC recommendations.

MHSA Accomplishments and Areas of Concern

The report recognizes "an anecdotal sense that the act has made California a better place for the estimated 2.2 million adults with a mental health need and their families." LHC "heard no testimony that the act has not worked." To the contrary, the report states that throughout its review, LHC encountered "enthusiastic support for the Mental Health Services Act and the changes these funds have generated within the state's public mental health system." The LHC report particularly praised how the MHSA has "changed the mental health system for the better" including:

- A more proactive help-first system that intervenes before people reach the point of a mental health crisis while "steering up to 80 percent of funding toward Californians with the most serious mental illnesses."
- More efforts to reach people "who might otherwise fall through the cracks, particularly those unable or reluctant to seek care in traditional institutional or office settings" and who might not otherwise seek help.
- New emphasis on wellness, recovery, resilience and hope.
- Sustaining the state's mental health system through a severe economic recession.

Significant Concerns: Oversight, Accountability, and Outcomes

Despite the positive changes as a result of the MHSA that diverse stakeholders report, the LHC expresses several significant concerns, the most fundamental of which is a lack of comprehensive evidence of outcomes: "Funding provided by Proposition 63 – now more than $1 billion annually and representing

about 25 percent of California's overall mental health spending – continues to evade effective evaluation." The report states that California "can't clearly show, much less measure, what more than $13.2 billion has accomplished in terms of improving services for the estimated one in six California adults with a mental health need or the one in 20 who suffer from a serious mental illness."

The primary causes of this problem, according to the report, are "overlapping and sometimes unaccountable bureaucracies" and "antiquated state technology" that impedes comprehensive statewide evaluation and reporting. The report concludes, "Though the act appears successful in improving the range of mental health services provided in California, the state must now take steps to ensure that it can demonstrate those outcomes to voters, taxpayers, mental health advocates, patients and their families." The following are brief summaries of each LHC concern.

Inadequate and Overlapping Oversight Structures

A critical priority, according to the report, is "strengthening state and county oversight of spending and programs for mentally ill Californians." LHC believes that structural problems in the MHSA contribute to inefficient and inadequate oversight that weakens "accountability for the act's performance and outcomes." A key problem cited is insufficient oversight authority for the MHSOAC, "envisioned to ensure that the annual $1 billion investment in the mental health system is achieving what voters intended." The state "lacks a strong oversight body that is empowered to monitor and oversee expenditures," according to the report.

LHC points to a "diffused authority" structure – originally between the Department of Mental Health (DMH) and the MHSOAC – with continued "overlapping bureaucratic oversight" between the MHSOAC and DHCS, resulting in "bureaucratic confusion." The report points out that from stakeholders' perspectives, state oversight is "a confusing patchwork of overlapping responsibilities."

Lack of Sanctions for Counties

A critical structural problem, according to the report is, the lack of a mechanism by which the state can hold counties accountable, including to "effectively impose sanctions, when necessary, to ensure the act is implemented and delivers the results voters were promised." According to LHC, it is "imperative that the state exercises its authority to ensure that each county spends the money as allowed by law – and is sanctioned accordingly if it does not comply." The report is concerned also with MHSOAC's inability to impose sanctions if counties fail to provide required data: "Until a state watchdog agency can ensure repercussions for counties that fail to provide required information about their implementation of the act, the state will not be able to collect data consistently and its evaluative efforts will continue to be hampered."

Self-Certification: One-Stop County Accountability Structure

The report states, "Among the consequences of the Legislature's modifications of the original 2004 Mental Health Services Act, few are bigger than the current overall lack of state control over how counties spend their funds." The report points out that Legislature-initiated changes, namely lack of state approval replaced by self-certification of counties' budgets and program plans (except for Innovative Projects), and automatic dispersal of MHSA funds created oversight problems. The system, according to LHC, is a "one-stop accountability structure" that "needs prompt and dramatic review." The new system, according to the report, has resulted in "little monitoring or oversight of county programs, including the potential mishandling of state funds."

The report observes that the Legislature made the changes to speed the disbursement of MHSA funds in the face of "excessive bureaucracy that made distributing money to counties overly complicated." It also notes that the Commission approved PEI plans in an average of 28 days, compared to DMH review times that exceeded more than 90 days for the majority of counties and for seven counties ranged from 180 to 336 days.

Inadequate Data System

According to the report, a critical problem is the lack of availability and inadequacy of data: "Without conclusive data no one knows how far the state has come in addressing mental illness through the act and how far it still has to go." The report points out that the lack and inadequacy of data "is particularly concerning for advocates for the state's varied ethnic communities who fear there are gaps between needs and services tailored to their communities." The report also links the lack of adequate data to the inability to addresses charges by critics that MHSA funds have been used inappropriately or ineffectively.

The report notes testimony that the current data system is "antiquated," inflexible, problematic, and limited, despite "$3 million of MHSA funds to upgrade the department's data systems."

Recognizing the specific impact of data limits on the work of the Commission, the report states "The oversight commission, however, must rely on the department and counties to provide the data it needs to evaluate programs funded by the act. Getting that data can sometimes prove difficult" and adds, "The oversight commission, which is in charge of evaluating the act, does not have access to complete and timely data about counties' programs in the various component areas." The report expresses concern that counties do not "consistently or completely comply with reporting requirements" and cites a lack of consistency of state data.

The LHC report includes MHSOAC testimony that "without a stronger data system that produces accurate, complete, meaningful and timely data, the state will be unable to perform its oversight role adequately and produce a comprehensive, outcome-based evaluation of the MHSA funds."

Transparency and Accessibility of Available Information

The report charges that the MHSOAC "must be able to better tell who has benefitted from the act and how" and that "Californians should be able to see exactly how much money has been raised through the Mental Health Services Act and have at least a broad understanding of how and where that money is being spent, by county and by component." The report noted that partial information is scattered among various state, county, and associated organizations' websites, but is not available in an organized or comprehensive way that is useful or understandable. Without a "single repository for information about the act" it is extremely challenging to compare plans or programs or note trends. Counties' Annual Revenue and Expenditure Reports, Three-Year Program and Expenditure Plans, and Annual Updates are not available on the MHSOAC or other state web site. There are no clear financial summaries with sufficient or relevant detail. With regard to MHSA-funded programs, the only comprehensive report is produced by NAMI.

With regard to evaluation, the report praises the wealth of information available on the MHSOAC web site but states that it "is not organized in a way that makes it easy for an interested, but uninformed, Californian, to understand how the state is monitoring and evaluating progress towards the act's goals."

According to the report, despite data shortcomings, available information could be considerably more accessible and useful; the report includes specific suggestions about content and format.

Insufficient Oversight of MHSA State Administrative Funds

The report also concludes that there is weak oversight of MHSA state administrative funds, with no comprehensive evaluation of the extent to which these funds are being spent to further the purposes of the Act. The report praised the Commission's Financial Oversight Committee for hosting presentations from the entities receiving administrative funds and developing a format to communicate findings to the Commission as a whole.

Conclusions Regarding California's Initiative System

The report notes frequent concerns that the "direct democracy" of California's voter initiative option has become "a favorite tool for powerful current interests." The LHC is especially interested in the MHSA provision that allows the Legislature with a two-thirds vote to amend the act consistent with its purpose and intent or by majority vote to clarify its terms. The report concludes that the changes that the Legislature has made – which the report describes as "sometimes dramatic actions"– have played a "key role in guiding implementation." The results of legislative changes, the LHC Commission believes, have been mixed, including "an oversight structure and funding process that is different from what voters initially approved." LHC views these changes as a "step in the right direction," particularly the greater independence of the MHSOAC. Overall, the report concludes that the MHSA experience demonstrates benefits of allowing the Legislature to modify an initiative, noting that "the ability of lawmakers to amend the act, once implemented, appears to have allowed it to weather changes in the state's policy and fiscal environment while generally staying on course toward outcomes promised in 2004." However, the report also notes that the changes have occurred "under the watchful eye of Senator Darrell Steinberg, Senate President Pro Tem from 2008 through 2014, and co-author of the Mental Health Services Act," and it is unknown what changes or impact would have occurred or might now occur under different circumstances.

Other Points in LHC Report

- The LHC's early reports on mental health issues and trends in California were influential in the development of Proposition 63, including the inclusion of prevention and early intervention and the recommendation to convene a Commission representing the diverse sectors of society affected by untreated or inadequately treated mental illness.
- The report states that there is a useful role for the state to expand training and technical assistance for counties and stakeholders, particularly to "identify model programs and help ensure those types of programs are adopted statewide."
- The report describes strengths and challenges with regard to the community planning process: the "best part of the Act" according to some stakeholders that responds to the wide differences among counties, and also a possible arena of lack of adequate resources and expertise that results in statewide inconsistency.

MHSOAC Current Activities Relevant to LHC Recommendations

Staff supports the recommendations of the LHC Report. In addition, the MHSOAC is already working in a number of areas that are relevant to the report.

1. *Proposed PEI and Innovation Regulations:* The State lacks regulations for these two MHSA components. MHSOAC's PEI regulations will, for the first time, include consistent fiscal and program reporting requirements to provide coherent and systematic information about the use of PEI funds. Because PEI programs will be defined in terms of their intended outcomes, it will be possible to track the use of PEI funds for these purposes (e.g. programs intended to reduce homelessness as a consequence of untreated mental illness). In addition, for the first time, almost all PEI programs will be required to report outcome data, providing the opportunity to understand the impact of expended PEI funds.

   Proposed Innovation regulations provide a framework for counties to design, pilot, and evaluate new and changed mental health practices with the goal of adopting and disseminating those that demonstrate success. The regulations strengthen Innovation reporting requirements and increase emphasis on disseminating successful practices.

2. *Statewide Data system:* In response to the lack of comprehensive and consistent data needed to evaluate the MHSA and broader mental health system fully and meaningfully, the MHSOAC has invested close to 3 millions of dollars to support current systems that provide limited data for the Community Services and Supports (CSS) component. The MHSOAC continues to work with the DHCS to support these legacy systems. Although these efforts have helped maintain and strengthen data collection and reporting, many major issues cannot be addressed with this level of effort: for example, addition PEI data and modification of the CSS system to track and report additional outcomes are not currently collected.

   To provide the State with robust and consistent data on behavioral health programs and outcomes requires designing and implementing a new Statewide Comprehensive Behavioral Health Data System. In partnership with DHCS, MHSOAC is working to develop and submit to the Federal government a Planning – Advanced Planning Document, which it is hoped will generate federal dollars estimated to fund 75% of the forthcoming planning and implementation phases. Formal planning may begin within the year and will be followed by an implementation phase: development and submission of an Implementation – Advanced Planning Document to the Federal government. It is expected that the implementation phase will conclude with awarding of a contract to vendors to build and implement the new Statewide Comprehensive Behavioral Health Data System, which should be completed by 2019 – 2021.

3. *MHSOAC Website:* The Commission is overhauling its website and will highlight on its homepage a visible link to MHSA revenues, both annual and cumulative. It will also incorporate data about populations that benefit from the Act and data to demonstrate statewide trends on key indicators to illustrate how and for whom the Act is working. The MHSOAC Prop 63 web site already includes a weekly rotating showcase of county programs that highlight their MHSA programs and outcomes; this feature will be highlighted on the revamped MHSOAC website. The MHSOAC website will also house counties' MHSA plans and reports submitted to the state, including annual revenue and expenditure reports, three-year program and expenditure plans,

annual updates, reports from the counties that receive triage grants, plus any other relevant mental health reports.

4. *Evaluation of Performance Outcomes*: The Commission is actively working toward this goal. In 2013, the Commission adopted an Evaluation Master Plan and associated Implementation Plan to guide its evaluation efforts. Per the Evaluation Master Plan, the Commission begins a series of new evaluation activities each fiscal year and is in the midst of developing activities scheduled to begin in Fiscal Year 2015/16. In addition, the Commission has continued to partner with the California Mental Health Planning Council, DHCS, counties, and others to continuously monitor the performance of the MHSA and broader public community-based mental health system.

5. *Training, Technical Assistance, and Support:* The Commission is fully committed to working with partners to ensure that counties have the needed knowledge and resources to carry out evaluations and report outcomes of their MHSA programs. This commitment includes training and technical assistance, consistent with the Commission's adopted policy paper, and also providing the necessary systems to support counties' evaluations and reporting, including new requirements in adopted PEI and Innovation regulations.

6. *Logic Model:* The Commission's adopted Logic Model supports and includes all of the oversight and accountability roles that the LHC Report considers to be essential for it to carry out its critical statutory role.

Conclusion

The LHC report emphasizes that the critical importance of fulfilling the MHSA promise extends broadly: "As California continues to experiment with mental health treatment programs, particularly for prevention and early intervention, its successes likely will inform how care is provided throughout the United States. Having data that ensures the best possible implementation will make the transformative effect of this act even more significant." This critically important goal requires collaboration, courage, and perseverance, to which the Commission is fully committed.

Date

Commissioner Victor Carrion
Chair
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioner Carrion,

The OAC Community Forums have been valuable venues for stakeholder input throughout the state since they were first conducted, with attendance increasing over time. The reports generated from the forums have highlighted both positive outcomes of the MHSA and information about the challenges experienced by adult and older adult clients, parents of both children and adults, other family members, peer providers, TAY, and county staff. Since 2011, the planning workgroup consisting of members from the Client and Family Leadership Committee (CFLC) and the Cultural and Linguistic Competence Committee (CLCC) have been supported by both staff and Commissioners. **However, there has been a lack of**

transparency when decisions are made about selecting forum locations and workgroup members later learn of those decisions without their direct involvement in the decision-making process.

In September 2013, staff of the Community Forums workgroup solicited suggestions from its members for locations in the following year. A previous forum locations map covering the periods from 2010-2013 was shared with workgroup members who then submitted suggestions for locations that would include reaching underserved and under represented groups in counties that had not previously been reached or needed to be re-visited. Although neighboring counties are always invited, access was often a barrier having to get to the forums. Locations for the 2015 Forums were not reflective of the suggestions made by the planning workgroup.

Stakeholder representation from vulnerable groups with various cultural backgrounds has been minimal and non-existent in some places. We hope that as the forums progress and special focus group-type outreach settings will be developed, there will be targeted effort to go to locales like Imperial County and

other places where we see increasing diverse constituencies, including some of the counties in the Superior region of the State where people struggle with isolation and daily hardships.

An organization like REMHDCO was instrumental in garnering attendance from underserved groups at the latest forum in Ventura. Such an organization and the CA MHSA Multicultural Coalition (CMMC), among others, can be good allies supporting this important outreach for diverse cultural stakeholder participation.

Sincerely,

Raja Mitry

cc: Toby Ewing