Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

General Stakeholders Meetings #3

June 1, 2005 – Sacramento
June 3, 2005 – Los Angeles

Combined Meeting Summary

For Discussion Only

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I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The general stakeholder meetings on June 1 and 3, 2005 were the third set of general stakeholder meetings for MHSA. The June 1 meeting in Sacramento and the June 3 meeting in Los Angeles used the same agenda to provide the opportunity for stakeholders in two parts of the State to provide additional feedback to DMH, especially on the revised May 18, 2005 DRAFT MHSA Community Services and Supports Three-Year Program and Expenditure Plan Requirements (Revised Draft CSS Plan Requirements), to learn about progress on the joint training collaborative and the CSS county planning estimates, and to discuss involuntary services and MHSA with Stephen Mayberg, Ph.D., Director, California Department of Mental Health.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m. on both days, provided an opportunity for clients and family members to discuss the afternoon workgroup session, review the stakeholder meeting agenda, ask questions, provide feedback, and discuss the recently released county planning estimates for CSS. Both the pre-meeting and the stakeholder meeting were introduced with the same general overview. The afternoon stakeholder meeting was held from 1:00 – 4:00 p.m. on both days.

Eighty-five (85) people attended the morning CFM pre-meeting in Sacramento and 59 attended in Los Angeles for a total of 144 clients and family members. One hundred fifty (150) people attended the afternoon stakeholder meeting in Sacramento and 90 attended in Los Angeles for a total of 240 stakeholders.

This summary reflects the combined content, questions and comments from both the June 1 meeting in Sacramento and the June 3 meeting in Los Angeles.

A. Meeting Purpose

The purpose of the general stakeholder meetings on June 1 and June 3 was to:

1. Review major changes in "Mental Health Services Act Community Services and Supports Three-Year Program and Expenditures Plan Requirements" revised draft

2. Identify progress on implementation of the Constituency Outreach and Education Collaborative (COEC) with Client Network, UACC, NAMI and MHA-California

3. Learn about county planning estimates for Community Services and Supports

4. Discuss issues related to involuntary services and MHSA.

B. Schedule of Meetings

Upcoming workgroup and conference call dates are:

- June 7 – Conference Call on Performance Measures and IT
- June 9 – Conference Call on Education and Training
- June 10 – Conference Call on County Planning Estimates
- June 15 – Conference Call on Capital Facilities
- June 16 – Workgroup on Education and Training
- June 23 – Workgroup on Capital Facilities and Workgroup on Performance Measures and IT
- July 11 – Conference Calls on Performance Measures and Education and Training
- July 18 – Workgroup on Performance Measures and Education and Training
- July 20 – Conference Call on Capital Facilities
- July 26 – Workgroup on Capital Facilities

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Eighty-five (85) people attended the morning CFM pre-meeting in Sacramento and 59 people attended the CFM pre-meeting in Los Angeles for a total of 144 clients and family members.

A. Welcome and Introductions

Bobbie Wunsch, Pacific Health Consulting Group (PHCG) and facilitator of the MHSA stakeholder process, introduced the client and family member session by reminding people of upcoming dates for the MHSA stakeholder input. Spanish and American Sign Language interpreters were introduced in both Los Angeles and Sacramento. Ms. Wunsch encouraged participants to reach out to others who may not be attending stakeholder meetings because of perceived translation barriers to let them know that

language and signing accommodations are available to encourage wider stakeholder input and participation. Ms. Wunsch encouraged people to arrive a few minutes early so the meeting could start on time. She introduced three high school seniors attending the Sacramento meeting and noted that DMH is developing a plan to include transition-age youth to obtain their feedback.

Ms. Wunsch clarified the differences between workgroup meetings and general stakeholder meetings. Workgroup meetings focus on one topic, address that topic in depth and draw people with special expertise or particular interest in that topic. Conference calls, which occur about a week before each workgroup meeting, are provided to orient stakeholders to the issues to be discussed at the workgroup meeting. Stakeholder meetings address several topics to update people on progress of MHSA.

B. Review of Agenda

Ms. Wunsch reviewed the agenda for the afternoon general stakeholder meeting and dates for upcoming meetings and conference calls. She noted that these meetings are the opportunity for everyone to be heard. Carol Hood, DMH Deputy Director, was available to answer CFM questions on MHSA implementation to date.

Client and Family Member Questions and Feedback

Housing Issues:

- What has happened to the workgroups on housing? Have they been subsumed into capital facilities?
  - **DMH Response (Carol Hood (CH)):** MHSA includes funding for capital facilities and information technology (IT). The capital facilities component includes housing. Information on capital facilities, IT and education and training will be released next week.
  - **Pacific Health Consulting Group (PHCG) Response:** The meeting on June 16 is on education and training. The meeting on June 23 will have two workgroups – "Performance Measurement and IT" and "Capital Facilities."
- The Governor's May revise mentioned diverting money from Prop. 63 to another program. Please clarify this.
  - **DMH Response (CH):** DMH has discussed jumpstarting some issues. The Governor, meanwhile, has announced an initiative to address the needs of people who are homeless, many of whom are mentally ill. He has asked State departments that have a housing component to coordinate efforts. Money is expected to come from many departments, with a proposed $2.4 million from MHSA.
- This sounds like a good use of MHSA funding, but what does it say about the MHSA planning process?
  - **DMH Response (CH):** Principles were established at the Short-Term Strategies Workgroup that include housing for the chronically mentally ill. If DMH were to wait for the planning process to be completed, many important opportunities may

be missed. At the same time, DMH is trying to follow the principles set by the planning process.

- Will this proposal be covered in the capital facilities and IT meeting on June 23?
  - **DMH Response (CH):** The proposal is still in a conceptual phase. DMH will share what is known at that time. Staff will also discuss a paper about the Department's anticipated approach to capital facilities funding over the three-year period. The Governor's proposal is for about $2.4 million in funds that are currently available.
- How can the Governor take $2.4 million from MHSA funds?
  - **DMH Response (CH):** There is five percent in MHSA for state operations. The Governor believes his proposal can use these "state operations" funds for this project, including hiring staff, etc. The Governor's proposal does not include direction regarding local funds.
- Where does the state government's housing money come from?
  - **DMH Response (CH):** Funding for housing comes from a variety of departments, including, but not limited to, Department of Social Services, Housing and Community Development, California Housing and Finance Authority (Cal HFA), Franchise Tax Board which issues tax credits, and DMH. It would be better for the people in need if there were a central place to access funding.

Supplantation

- What does "supplantation" mean?
  - **DMH Response (CH):** Supplantation means replacing old funding with new funding. MHSA says a county may not redirect current county or state mental health funding to pay for something else in the county budget when MHSA funding starts. The definition of supplantation is a complex legal and financial issue. DMH wants a definition established that will pass judicial scrutiny.
- What is the status of the supplantation legal decision?
  - **DMH Response (CH):** The State legal and finance departments are currently working on the budget, so supplantation decisions are on hold for the moment.

Process Issues

- How can Carol Hood be contacted by email?
  - Carol.Hood@dmh.ca.gov.
- June 23 is an annual training for consumers on compliance. Can something be done about this conflict since many consumers will not be able to attend?
  - **DMH Response (CH):** DMH will see if something can be done.

C. Recruitment for the Mental Health Planning Council

Alice Washington, member of the California Mental Health Planning Council and Tina Wooten, DMH staff, announced that the Council is in the process of recruiting new members to fill three openings. The Mental Health Planning Council has dual mandates

from the state and federal government. Its responsibilities include reviewing SAMHSA (federal mental health) funds, advising DMH about policies, reviewing evaluation of accountability measures, assisting in development of the State mental health plan, assessing mental health realignment funding, and assisting local mental health boards to make sure they effectively carry out their duties. The Planning Council will collaborate with the MHSA Oversight and Accountability Commission. The Planning Council is diverse in terms of culture and language; half of its members must be clients or family members and the other half are state department staff, professionals and providers. Applications can be downloaded from the DMH website. Completed applications should go to the DMH Director's office.

Client and Family Member Feedback

Eligibility and Selection Criteria

- Does the governor appoint the members?
  - **Planning Council Response:** The director of the California Department of Mental Health, with the acknowledgement of the Health and Human Services Agency, appoints the members.
- What positions are open?
  - **Planning Council Response:** The openings right now are for a consumer and two consumer-related advocates.
- Do consumers have the opportunity to join?
  - **Planning Council Response:** Yes.
- As a consumer, I applied to the Council and was turned down. What is the Governor looking for?
  - **Planning Council Response:** DMH staff are not involved in selection of members. Governor seeks a balance of ethnicities, geographic representation, family members, children, teens, new people who have not been involved in the processes, etc. DMH does not know the specifics of any particular application.
- Is geographic representation important?
  - **Planning Council Response:** Meetings are held throughout the State. The Planning Council wants to achieve statewide geographic representation.

Application Process

- What is the deadline for application?
  - **Planning Council Response:** There is no deadline; the application process is continuous.
- Is the Council completely volunteer?
  - **Planning Council Response:** Yes, but it reimburses for expenses such as transportation.
- Why does the application ask for social security number? Why does it ask if the applicant is registered to vote? Why does it ask for party affiliation?
  - **Planning Council Response:** Applicants' social security numbers are kept confidential.

- **DMH Response (CH):** DMH will check on the voter registration and party affiliation questions.

Council Participation

- Do new members receive training in their responsibilities?
  - **Planning Council Response:** When someone is appointed, the Planning Council provides a mentor who has been on the Planning Council for years. New members sit with their mentors during the meetings and can call them for questions. There is also an orientation for new members.
- How often does the Council meet?
  - **Planning Council Response:** There are Planning Council meetings four times a year and conference calls in between. The Planning Council has functional committees that also meet regularly throughout the year. These committees are Quality Improvement, Human Resources, and Policy and System Development.

D. Constituency Outreach and Education Collaborative (COEC)

At the Short-Term Strategies Workgroup session on March 16, 2005, stakeholders recommended that DMH fund training for clients and family members to participate in the county planning processes. DMH quickly responded by issuing a Request for Proposals for a six-month, $150,000 grant to create a collaborative for training. This RFP was directed at the four statewide advocacy groups, the California Network of Mental Health Clients (Client Network), Mental Health Advocates of California (MHAC), NAMI-California (NAMI) and United Advocates for Children of California (UACC).

Representatives from the Client Network, MHAC, NAMI and UACC presented concepts for the training collaborative. The Sacramento presenters were MHAC Associate Director Stephanie Welch, NAMI-California Executive Director Grace McAndrews, UACC Executive Director Jennifer Clancy, and Client Network Executive Director Sally Zinman. The Los Angeles presenters were MHAC Associate Director Stephanie Welch, UACC representative Roberto Ramos, and Client Network representative Blanca DeLeon. Stephanie Welch presented on behalf of NAMI in Los Angeles. Presentations of the training collaborative were made during the CFM pre-meetings; a briefer summary was provided during the afternoon general stakeholder meetings.

The purpose of the joint training collaboration is to conduct outreach and to provide support, education and training to underrepresented and underserved communities and people not yet at the table, in order to broaden participation in state and local MHSA planning and implementation. The target underserved groups include but are not limited to: communities of color, young people, gay /lesbian/bisexual/transgender/ questioning communities, people who are geographically isolated, older adults, community services providers, primary care clinics, faith communities, schools, and, essentially, any stakeholder who needs the tools to participate effectively in the MHSA process.

The four member organizations are excited about collaborating together to address these outreach and training needs. They are working closely together to make the best use of limited resources. They consider this grant a pilot project, which will be leveraged with funding from The California Endowment and the California Wellness Foundation. The collaborative will start with a county approach in seven counties. The first four counties targeted will be Alameda, Fresno, Los Angeles and San Diego, selected because of leveraged funding. Three other large counties will be identified at a later date. COEC also wants to conduct at least one regional rural training. The ability to do so, however, is reliant on community resources. The level of county support will decide how much rural training the collaborative can provide.

This training can offer counties assistance in reaching the people they are required to include in their planning processes. It is important to recognize that funding is limited, thereby limiting how extensive the outreach can be. At the same time, collaborative members have been successful in bringing in additional foundation grants to extend the project's reach. In addition, COEC members hope that counties will use some of their planning monies for stipends and transportation costs to help people attend.

MHAC will provide the staff coordinator of COEC for the initial six months of operation, building upon foundation support. This staff member will be housed at MHAC in Sacramento but COEC will have a dedicated phone line and separate letterhead. The Client Network will hire a multicultural outreach worker.

COEC reflects collaborative relationships among advocacy organizations and models the kind of work envisioned in the MHSA. COEC member organizations are eager to outreach to and exchange knowledge and experience with underserved and underrepresented communities, and to empower these constituencies to become advocates for MHSA mental health services and supports that meet their unique needs.

COEC is committed to accountability and will measure outcomes to ensure that goals are met or that barriers to achieving goals are identified.

COEC has two goals: 1) use the forums to identify people from underrepresented and underserved communities and see how many remain involved in process and 2) identify the barriers to meaningful and significant participation. In order to achieve meaningful involvement, it is important to learn the most successful strategies. Toward that end, COEC is actively soliciting input from clients and family members statewide.

COEC members developed principles for the project to address the organizations' very different world views, recognizing that outreaching to underserved communities is a complex task and that different geographic areas and populations will require different approaches in order to be effective. They see this as a learning process for themselves and the communities they will be reaching. COEC does not plan to tell communities what they need, but to work in partnership with them. They are committed to accountability and want to identify how effective their training sessions were.

Training forums will probably be day-long trainings. Part of the session will provide basic information and materials to all participants. Then the participants will divide into groups according to their constituency. The Client Network will work with consumers; MHAC will work with representatives of transition-age youth organizations, community service organizations and other service entities currently serving consumers and family members in non-traditional settings; NAMI will work with family members of adults; and UACC will work with family members of children.

In the end, COEC wants to empower new people who have not come to the table to achieve and advocate for recovery and wellness. Members also hope that by this time next year the group presenting the results of COEC trainings will represent the diversity of California.

COEC seeks input from clients and family members for effective strategies. Collaborative members can be reached at the following emails:

- rramos@uacc4families.org
- phawkins@uacc4families.org
- grace.mcandrews@namicalifornia.org
- main@californiaclients.org
- swelch@mhac.org

Client and Family Member Feedback

Strategies

- One of the issues in the very small counties is that there is a specific small county culture. Small county departments lack sufficient staff people to do what the larger counties can accomplish. Our county was one of the first counties to provide "client consultants," who are the people who know what is missing in the county. People feel they are not wanted in the county and that no services are offered to consumers. Money does not buy trust. Building trust involves offering services. Counties need to find out what the local needs are without making people come to more meetings.
- San Joaquin County has a "pal's support process" which works.
- Our planning group has been attempting to bring the county's 23 school districts to the planning meetings. Does the collaborative have any ideas?
    - **COEC Response:** It always helps to provide incentives. It can help to involve their leadership first. It might help to start with the leadership at the state level and ask them to urge their county counterparts to participate. Show how MHSA can benefit schools as it is often teachers who are the first to see children who are hurting.
- Schools want some of the MHSA money. Our county is working collaboratively with schools and the public health department.

- It often seems that people working on MHSA at the county level want the other departments involved but want them to bring their money with them to the table, which is a deterrent to participation. They do not see a reason to come.
    - **COEC Response:** Every county is different. It is important to use contacts to bring people in. Let them know that money may be available later. Inform and involve people in leadership and show them how their agencies can benefit later.
- SAMHSA has a number of resources that could be useful to offer to school districts. By offering them something, it will be more inviting.
- Everyone wants to get involved. Develop a handout that can be distributed at meetings so people can share information. It will help the collaborative process.

Client Networking

- There is a need for a client networking team that can be established without a lot of money by creating a database of email addresses, producing a newsletter, rotating responsibility from county to county so that the burden is shared. This has not been done and could help in the networking process.
- Consumers need assistance in building and maintaining networks across the State. The proposal made at the Short-Term Strategies Workgroup was to support networking among clients, who are the most disadvantaged, poorest and least able to participate. It is not possible to start client organizations without networking among clients. COEC has four organizations and only one represents clients. Clients and consumers are outnumbered and underrepresented in this collaborative.
- Education about MHSA is not client networking. Clients need to get together across the State. How did client networking turn into client education?
    - **COEC Response:** There were restrictions to this funding. Networking was not part of the proposal. What DMH offered was collaborative training and outreach. The partners wanted more, but did not get everything. It is important to realize that we cannot always get everything we want. The Client Network will use its funding to network with clients.
    - **COEC Response:** It is disturbing to hear someone raise the ratio of 1:3 meaning one group for clients and three representing families. The Client Network values are very clearly articulated and the Network has very strong leadership. We do not always agree but we are working together and are committed to the concept of transforming the way we work together and to model the process of hearing everyone's voices and building mutual understanding.
- In the large meeting, this collaboration was seen as potentially an unholy alliance. But we are making the best of the situation. We are frustrated. There is not enough money. There is not enough money to transform the system on the pittance provided within a bureaucratic process. We need to sit back and take a deep breath. We must try to work together and not let our crisis of expectations undermine our enthusiasm.
    - **COEC Response:** We are all faced with the sense that transformation has to come about with additional resources and there are not enough resources.
- Client networking does take place, but more is needed.

- This is a good start, there is a lot more needed than the $150,000 to show results. There is a networking component built into the Client Network trainings. In this process, COEC should show special sensitivity to people who are reluctant to participate.
  - **COEC Response:** The collaborative members hope for cooperation from everyone. The members believe COEC will start out small and can expand across the State.
- Remember the motto, "Nothing about us without us." COEC appears to be doing something about something without the right people. Is the collaborative talking to the right people? Is it talking about the right people? Hope on the streets for MHSA is different from hope on the streets for AB 2034. People are on the streets, with their carts, without hope. Is the collaborative "doing nothing about them without them"?
  - **COEC Response:** COEC has a commitment to conduct inclusive outreach. It is a learning process. It is a knowledge exchange. The collaborative is not going to tell people how to do this. MHAC has been doing advocacy for years and understands that it needs to change so that underserved communities will want to be involved or be mental health advocates for themselves. Collaborative members want to learn from the communities not currently at the table. MHAC looks forward to the day when everyone in the mental health system can come together without labels (consumer, family member, advocate, provider).
  - **COEC Response:** The Client Network will prioritize networking at the meetings. COEC knows it has to reach regional and rural areas. The email addresses have been posted so everyone can feed back to the collaborative their ideas for how this outreach can occur.
  - **COEC Response:** The collaborative members' philosophy of inclusion means that everything is not in concrete until consumers and family members have had the opportunity to provide feedback.

Target Groups and Potential Partners

- Two of the tribes in Mendocino County submitted applications to the State in January, requesting money to conduct outreach to tribal communities. These applications were ignored. The organizations in the collaborative got this training money because DMH knows them. How will the State or counties reach out to rural tribal communities which are routinely ignored? Tribal outreach now depends on volunteers and it is hard. Outreach workers need to know the people they are reaching out to. Why was there no consideration to fund a group like ours?
  - **DMH Response (CH):** The Department decided to work with statewide organizations to develop a statewide collaboration. DMH understands that the issues are different for tribes. Please send a copy of your application to Carol Hood's attention and DMH will follow up on the request.
  - **COEC Response:** COEC wants to reach Native Americans. Talk to any of the members so that the collaborative can determine how best to outreach to your community.

- Go to Native American tribes. Recruitment will be challenging as often Native Americans trust only certain people. Also, family members deny their family members need help.
  - **COEC Response:** The collaborative is very excited to include tribal communities.
- Is COEC working with California Pan Ethnic Health Network?
  - **COEC Response:** That is a great idea. The collaborative hopes that if this first round of funding is successful, more will be forthcoming and we can expand to include other groups, including this group and others such as the California Primary Care Association.
- Go to hospice, because people facing death or the death of their loved ones often have mental health issues, especially depression.
  - **COEC Response:** Certainly people dealing with the death of loved ones are an important group to reach out to.
- Is COEC planning to reach the public health departments as well?
  - **COEC Response:** Many consumers find services to meet their mental health needs through the public health system and it is very important to include them.

Access to Training and Materials

- Why were these counties (Alameda, Fresno, Los Angeles and San Diego) selected?
  - **COEC Response:** The collaborative is using funding from The California Endowment to expand the project and the four counties were selected for that project. COEC is trying to spread additional forums throughout the State.
- Is COEC planning to work with smaller rural communities?
  - **COEC Response:** The collaborative hopes that smaller communities will provide financial support to allow the training forums to extend to their communities.
- Is COEC developing a set curriculum? Will it be available to the remaining counties?
  - **COEC Response:** Whatever materials COEC develops will be available. Currently, the collaborative is gathering information and hopes that everyone will email ideas to any or all of the members.
- When will consumers and family members have a chance to review the master curriculum?
  - **COEC Response:** COEC does not yet have a review process, but will develop one. The draft curriculum may be posted on a joint COEC website or each of the members' websites, and/or on the MHSA website. Consumer and family member feedback is critical.

Organizational Issues

- What is the timeline for implementation?
  - **COEC Response:** The project will be completed in the next six months. Collaborative members are expecting to gather information and put together materials in June and July. Trainings will start in August and finish in December.

- The COEC proposed session division into four groups has its pluses and minuses. It would be better to model interaction, especially for transition-age youth and adult clients.
  - **COEC Response:** That is a great idea. The collaborative will discuss it.
- The separation into different groups, both in this collaborative and in DMH's age group breakdown, may help to focus on the details of the work. However, it would be beneficial for someone with the vision that we are all one community to be there to pull us back together so we are focused on the whole age continuum, i.e., have an adult advocate, children's advocate, etc., in each group.

E. County Planning Estimates for CSS

Mike Geiss, DMH financing consultant (Sacramento presenter) and Carol Hood (Los Angeles presenter) provided an overview of the DMH Letter No. 05-02, Planning Estimates for Mental Health Services Act Community Services and Supports as well as the DRAFT Community Services and Supports One-Time Requests for Funding document. (Both documents are posted on the MHSA website.) The planning estimates are the annual maximum amount of funds available to each county to develop its CSS programs only. The amount will be paid quarterly in advance so counties will actually have the funding, after the CSS plans are approved. During the first year, the annual funding will be pro-rated, so that if a plan is approved by January 2006, it can have half the funding. These amounts will increased based on MHSA projections (1% in the second year and 6% in the third).

The total amount of money expected for MHSA in 2005-06 is expected to be $683 million. DMH can only estimate how much will actually be raised through the tax each year. The State has to wait for income tax returns and hope that the State's 25,000 millionaires all stay in California and do not incorporate as a corporation, which is exempt from the MHSA tax. There is no way to anticipate how much the fund will fluctuate over time. For example, at the peak of the dot-com bubble, the tax would have generated $1.2 billion, while two years later, the proceeds would have been only $440 million. The Act accommodates that ebb and flow by requiring that some funds be set aside in a reserve until it is clear how secure the funding is. DMH decided to only spend about 90%, in order to not risk cutting back the program shortly after starting it.

Half of MHSA's $700 million, or $350 million, is designated by statute for CSS. DMH decided to only disburse $315 million instead of $350 million to address the tax revenue uncertainty issue and other potential statewide priorities. The Department also concluded that it needed to give special consideration to the small counties. So every county and the City of Berkeley will start with a $250,000 base. This totals $15 million.

DMH then developed a formula for the remaining $300 million. Usually this is done using an equal split of the county's share of the State's population and its share of people living in poverty, using updated numbers. DMH used a more complex formula that started with these two factors and added in two adjustments.

In calculating the need component of the formula, DMH began with population data, using the 2005 U.S. Census data with population updates from the California Department of Finance. Some counties have been surprised by the population estimates. For example, Los Angeles has generally been estimated at 30-33% of the State's population, but is now down to below 30% because other counties grew at a faster rate. Total population accounts for 50% of the need portion of the formula.

Next, DMH looked at poverty, using the number of households with incomes below 200% of poverty. Increasingly many Californians have no insurance. So, the Department included in the poverty figure those with no insurance. This percentage accounts for 30% of the need portion.

For the third component of service need, DMH looked at prevalence rates of mental illness. According to national studies, prevalence varies by a number of factors, including gender, ethnicity and education level. The Department contracted with a national researcher who took Census data and national studies to assess prevalence data for counties. This calculation accounts for 20% of the need portion.

Next, DMH looked at two adjustments, each of which makes a 20% adjustment in the formula. The first is cost-of-living/doing business. It is more expensive to live in some places in the State than others. That difference affects costs of housing and staff salaries, thereby the cost of implementing MHSA. The Department used the Self-Sufficiency Index as the first of the two additional adjustment calculations.

Finally, DMH wanted to include a factor for unmet need. No one has yet figured out how to measure this, other than to acknowledge that every county has overwhelming unmet need. As a proxy, the Department assessed funds that counties already receive from both state and federal governments for mental health services. Some communities have received a larger share of resources from the state and federal government than others. DMH added up realignment, other state funding and federal grant funding. Medi-Cal Federal Financial Participation was not included. The formula made an adjustment so that the level of resources would come closer to the level of total need, so counties with a lower percentage of resources than their population received more funding and those with a higher percentage of resources than their population received less.

Out of all of those considerations, DMH arrived at a percentage for each county, which, added to the base $250,000, is each county's maximum annual planning estimate for CSS.

Using Orange County as an example: Orange County has 8.35% of the State's total population, but its share of the population in poverty is much smaller (7.1%), and its share of prevalence is even lower (6.6%). When these three percentages are factored together, the total need is 7.6%, because many people in the county either have insurance or can afford services. The Self-Sufficiency Index indicates that Orange

County is a high cost county, 28% above the state average. Finally, Orange County has received a smaller amount of state and federal resources than similar counties, only 5.5%, much lower than the total need of 7.6%. When all these factors are added together, the DMH formula found that Orange County should receive 8.47% of the CSS funding. This 8.47% is multiplied by $300 million and the base amount of $250,000 is then added to it for a total annual allocation of $25,502,200.

A county may also request funding for one-time expenditures that fall into any of three categories:

- **Extension of community program planning funding**

  A county may request an extension of county program planning funding up to 5% of their fiscal 2005-06 CSS planning estimate to fund continued planning activities. These additional funds are expected to be used when the initial distribution of planning funds is exhausted. This will be paid in one lump sum.

- **Pre-implementation of CSS funding**

  Upon submission of the program and expenditure plan for CSS, a county may request up to 25% of their fiscal year 2005-06 CSS planning estimate for pre-implementation activities. Types of allowable pre-implementation activities include, but are not limited to Request for Proposal development, issuance and review for programs and services proposed in the plan and all necessary human resources activities to recruit staff for the proposed MHSA programs and services. Counties are advised not to enter into contracts or hire additional service delivery staff until approval by DMH of the CSS plan.

- **Other one-time CSS funding**

  A county may also request funding for other one-time CSS expenditures outside the pro-rated maximum annual planning estimate. Types of allowable activities could include the cost of vehicles if purchased with MHSA funds or costs of equipping new employees with all necessary technology (cell phone, computer hardware and software, etc.). Counties may request up to the remainder of their fiscal 2005-06 CSS planning estimate.

Client and Family Member Questions and Comments

Funding Concerns and Questions

- Does DMH have to spend its part of the allocation to defend MHSA? What is not being funded as a result of this?
  - **DMH Response (CH):** DMH does not have the answer to that. Often, propositions lead to lawsuits. The Department is using some of its money for

other initiatives, such as COEC and a homeless initiative. Lawsuits could take away from such initiatives.

- What happens to the other half of the $700 million? Does DMH keep it?
  - **DMH Response (CH):** Funding is set aside for several different components including Education and Training, Capital Facilities, IT, Prevention and Early Intervention, Innovation, etc.
- Do Yuba County and Sierra County, which are working together, combine amounts of the planning estimates?
  - **DMH Response (Mike Geiss (MG)):** Yes.
- The amount of money is much smaller than what counties thought they would receive.
  - **DMH Response (CH):** Yes it is. The MHSA total is only $700 million, and CSS is only half of that. MHSA represents only a 10-15% increase of the total mental health budget, and many counties are still having to look at cutting services. MHSA will provide much less than people hoped for. This means counties have to set priorities. The planning process is where reality sets in. It is a 10% increase in a declining system.
- Los Angeles County's planning estimate is only $90 million. How will it use the money?
  - **DMH Response (CH):** DMH does not establish how each county spends its allocation. It is their decision.

Planning, Pre-Implementation and One-Time Funding

- Is this additional program planning funding?
  - **DMH Response (CH):** This money is for CSS implementation – the level of funding a county can expect to receive after its plan is submitted and approved. If a county submits its plan in October, it will take DMH until January 1 to finish the approval process. Please note, that the Department understands that this is an aggressive timeframe, which most counties will not meet. The Department does not want counties to start new services until the approval process has been completed. A plan approved in January will result in funding of only half the annual planning estimate for this year. However, there are other ways counties can bring in CSS funding. They can apply for expanded planning funds, using 5% of the estimate. Hopefully while waiting for DMH approval, counties will be moving forward. Counties can request 25% of their annual allocation for pre-implementation to get ready. This money is not for services, but for hiring, working toward Request for Proposal development, issuance and review for programs and services proposed in the plan and all necessary human resources activities to recruit personnel for the proposed MHSA programs and services, although it can not be used for finalizing contracts. Funds can also be accessed to pay for one-time expenditures, such as vehicles, computer equipment, for drop-in centers. One-time funding can be as large as the part of the county allocation that was pro-rated.
- What happens to the 50% of the funds that counties cannot access until the plan is approved in January?

    - **DMH Response (MG):** Counties will have access to pre-implementation, planning and one-time-only funding.
    - **CFM Response:** This is miniscule. Our county could have completed the planning process months ago and gotten the annual allocation. By requiring counties to include a broad spectrum of people, which takes a lot of planning time, money has been taken away from us.
- Let counties have the pro-rated funding flow into their reserve fund.
- Does pre-implementation come out of the total planning estimate?
    - **DMH Response (MG):** Yes.
- Can existing services receive one-time-only funding?
    - **DMH Response (CH):** MHSA cannot replace existing funding. MHSA one-time-only funding can go to existing programs that are expanding. No services can be started until the county's CSS plan is approved. For example, if an existing program plans to expand to provide mobile services, it could request one-time funds to purchase a van. DMH wants to make sure that before there is an investment, DMH has approved the county's CSS plan. One-time-only funds for programs or staffing cannot be spent unless and until the county's CSS plan is approved.

Funding Formula

- Was consideration given to non-English-speaking households and ethnic representation in developing the funding formula?
    - **DMH Response (CH):** DMH sent the draft out for comment. Non-English-speaking households was not suggested as a criterion. Ethnicity was suggested but without a means to do so and hence it was not included in the formula. DMH is considering including homelessness, but no reliable database reflects that. This formula is for the first three years. If DMH can determine a way to obtain a reliable statewide, county-specific database for homelessness over the next three years, homelessness may be added as a factor.
- Some counties received a small amount of money and they have specific concerns about the costs, including geographic isolation. These counties should receive more than the $250,000 base.
- Please explain whether the amount of money allocated to each county included any consideration to those counties who have many undocumented workers who do not appear in the Census figures.
- Please clarify whether over/under-equity county issues were considered in determining funding.

Other

- What is the priority between unserved and underserved populations? Are counties targeting services to leverage funding so that they will prioritize the underserved rather than the unserved? What is the State priority? Clients and family members in the current system are asking about unmet needs. But it appears that DMH is trying to prioritize the underserved.

- **DMH Response (CH):** DMH tried to specify that the priority population is those who are unserved or so severely underserved that they are still at-risk for serious negative outcomes (suicide, school failure, homelessness, etc.). DMH specified the populations it views as having priority, but wanted to allow counties to identify their own priorities.

- How are consumers and family members going to get the larger mental health system to say that MHSA is significant enough to transform the system? Does the county mental health director leadership buy in to transformation?
  - **DMH Response (CH):** County mental health directors have tremendous buy-in to transformation. Some counties are still struggling and there are people who are complaining about the amount of work, but the directors are committed. Meanwhile DMH is working to build a partnership with other state departments. Department staff know it is necessary to partner with them on issues of their priorities. The Department is behind some of the counties in these partnerships.
  - **CFM Response:** SAMHSA is running leadership workshops about transformation for the State.
- These stakeholder meetings have poor attendance here in southern California. Southern California is a lot bigger than one meeting location can accommodate. Hold meetings in other counties, such as Ventura.
- Counties need help in developing their plans.
  - **DMH Response (CH):** These are some of DMH's challenges. Some counties have many resources, some less. If the Department does not think a county has implemented a good planning process, that conclusion will be reflected in the outcome of the county's CSS plan review.

III. General Stakeholders Meeting (1:00 – 4:00 p.m.)

One hundred fifty (150) people attended the afternoon stakeholder meeting in Sacramento and 90 attended in Los Angeles for a total of 240 stakeholders.

A. Welcome, Introduction and Purpose of the General Stakeholders Meeting

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process welcomed the participants, introducing the Spanish and American Sign Language interpreters in both Sacramento and Los Angeles. Ms. Wunsch welcomed everyone to the third set of general stakeholders meetings.

B. Constituency Outreach and Education Collaborative (COEC)

An overview of the presentation by the Constituency Outreach and Education Collaborative (COEC), described in detail previously in the Client and Family Member

Pre-Meeting Section, was provided. Stakeholders in the afternoon sessions added additional comments.

Stakeholder Questions and Comments

- The Asian community has had trouble finding a way to talk to people in the planning process. The statewide Asian Pacific Islanders network suggests that COEC have a statewide conference, to see the variation among the different Asian populations.
- The funding for the collaborative does not seem sufficient. There is a lot of work and preparation time to get this process going.
  - **COEC Response:** All of the COEC organizations will be using their networks to find inexpensive or free places to have meetings and other ways to save money. Suggestions and feedback are vital to do this right.
- Three of the four organizations involved in COEC are family organizations. Where is the level playing field for clients?
- COEC plans completely disrespect the needs of smaller or rural counties. All seven targeted counties are large. This is not right.

C. Review of Major Changes in the "Mental Health Services Act Community Services and Supports Three-Year Program and Expenditure Plan Requirements" Revised Draft

Carol Hood provided an update on the major changes to the Community Services and Support Program and Expenditure Plan Requirements revised draft. The complete document can be found on the MHSA website.

Document Structure

The revised document was divided into three separate documents:

Document 1: Three-Year Program and Expenditure Plan Requirements

Document 2: Technical assistance document. The requirements were getting so complex it seemed to make sense to separate out technical assistance.

Document 3: The Reader's Guide is a summary of the requirements and MHSA. It will serve as an executive summary and will be translated into several languages.

The Purpose Remains Unchanged:

- Specify requirements and priorities
- Make sure county plans are consistent with MHSA
- Move toward system transformation
- Focus efforts and produce meaningful and measurable outcomes statewide

- Support local priorities within the above parameters

Overview of Changes:

- Incorporated stakeholder feedback
- Clarified and simplified plan requirements
- Increased emphasis on client and family programs, peer support efforts, self-help and client-, youth- and family-run programs in appropriate age groups
- More strongly embedded cultural competence
- Included small county exceptions and added additional strategies for small counties
- Added more strategies for outreach and engagement efforts
- Used more appropriate language for children and youth with more examples for all age groups and special needs populations and, in particular, incorporated CSOC and Wraparound core values and principles in strategies for children, youth and families
- Eliminated distinctions between structural and service strategies and expanded the range and types of strategies addressed
- Clarified that strategies may be funded by any of the three types of funding as appropriate
- Revised policy regarding use of MHSA funds for involuntary services:
    - Services and programs funded with MHSA funds must be voluntary in nature
    - Individuals, regardless of legal status, may access these expanded services

Individual Outcomes Included

The revised document also emphasizes individual issues and the importance of measuring specific outcomes achieved for individuals and families, including but not limited to hope, personal empowerment, respect, social connections, independent living for adults and safe living with families for children and youth, self-responsibility, self-determination and self-esteem for clients and families.

Expanded Language on Outcomes

- Meaningful use of time and capabilities, including things such as employment, vocational training, education, and social and community activities
- Safe and adequate housing, including safe living environments with family for children and youth and reduction in homelessness
- A network of supportive relationships
- Timely access to needed help, including in times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services, reduction in institutionalization and reduction in out-of-home placement

Five Fundamental Concepts

- Community collaboration
- Cultural competence
- Client/family-driven mental health system
- Wellness focus
- Integrated services

Three Types of Funding

- *Full service partnerships:* Not something that is "done" to the client, but requires a partnership: county commits to individual service plans, that are person- or child-centered, with individuals and their families given sufficient information to allow them to make informed choices; provision of all necessary and desired appropriate services and supports to assist in achieving the goals identified in the client's plan; and identification of a single point of responsibility, with a personal services coordinator (PSC) or case manager with a low enough case load to respond as needed and give the client or family considerable personal attention and 24/7 response capability.
- *System development:* Funding to improve or create structures, services; and gap funding to add a service that is not there or expanding a service that does not have sufficient capacity, such as peer support or mobile crisis.
- *Outreach and engagement:* Funds for outreach and engagement of those populations currently receiving little or no services, including mental health and primary care partnerships, partnerships with faith-based communities, tribes, etc.

Structure of CSS Plan Requirements

The CSS Plan Requirements Revised Draft has been divided into two parts. Part I addresses the county planning process, which must be approved by the State before the State will review Part II. DMH is impressed with how the counties have embraced the community planning process. Counties receiving full planning approval must document how they did what they said they would do. Counties with conditions will need much more documentation. The counties are encouraged to resubmit their plan-to-plan to get full planning approval, thereby requiring less documentation at the time of full plan submission.

Part II continues to follow a logic model. It links community issues resulting from untreated mental illness and lack of services and support, mental health needs within the community, the identification of specific populations to be fully served based upon the issues and needs identified, the strategies and activities to be implemented and the desired outcomes to be achieved.

Overall, counties must request the majority of their funding for Full Service Partnerships over the three-year period. Counties must plan for all age groups in the first three-year period, but there is no requirement that all three funding strategies for each age group

be used. All counties must develop and/or expand peer support and family education services within their three-year plan. Small counties can use community partners in addition to their service teams for 24/7 coverage for Full Service Partnerships.

DMH encourages counties to start their programs without leveraging funds and to look for additional funds only after a program is working. Many MHSA services can be used as a Medi-Cal match.

DMH wants stakeholders to provide feedback on the draft document and, specifically, to help identify errors, omissions, clarifications and ways to streamline the document. Most feedback so far indicates that the second draft reflects substantial improvement, but still requires work, especially in terms of streamlining and clarifying. All input is needed by no later than Wednesday, June 8, so that the final version can be completed quickly.

Stakeholder Questions and Comments

Streamlining, Clarification and Accountability

- The Department did a nice job on the revision. Would it be possible to put the counties' plans-to-plan on the DMH website? This will help stakeholders hold their counties accountable.
  - **DMH Response(CH):** DMH will investigate doing this, but will have to ask the counties to send their plans electronically. DMH Staff will begin to ask for electronic versions earlier on.
- There is too much unnecessary and nonsensical numerical complexity in the attachments.
- It is clear that DMH does not trust some counties. Have some failsafe provision that unspent money comes back to the MHSA fund.
- Let some community organizations organize parent/consumer advisory committees to be final arbiters, rather than the State. Treat us like grown-ups and let us monitor the programs that are implemented to see if they hit the mark.
- Is the intent of the assessment of the diversity on Page 38 to assess service providers?
  - **DMH Response (CH):** We are looking at the current direct service system and whether it reflects or is consistent with populations counties expect to be serving.
- This draft reflects a large amount of responsiveness from stakeholders. Does the sample program plan presented a few months ago that showed what the State was requiring still hold? It would be useful to share with our community.
  - **DMH Response (CH):** Yes, it still applies, but DMH will need to see much more content, as it is more conceptual.
- What is the review process by the local Mental Health Board? For example, is it correct that if the department issues its draft plan by July 15, then any time after August 15, the county mental health department has to analyze all the feedback?
  - **DMH Response (CH):** Once the county has completed its CSS plan, it is distributed to the community for a local review for 30 days. Then the Mental

Health Board holds a hearing to hear feedback on the plan. After that, the county has to summarize and respond to substantive comments.

Priorities

- It is important to reduce discrimination against people with mental illness. It is great that there are police officers who are here to hear us.
- It is important to remember the people who are placed out-of-county in IMDs, etc. so they do not lose touch with their families.
- Is there funding for evidence-based practice approaches?
  - **DMH Response (CH):** The core issue is whether there is reason to believe a practice will be effective. Evidence-based practices often require fidelity models that make deviation difficult. Evidence-based practices are often designed for a specific age group with a specific diagnosis in a specific environment. Often there is a mismatch.
- Can MHSA programs make what exists better?
  - **DMH Response (CH):** There are two facets. First, services are sometimes not intensive enough and the expansion of staffing resources will bring caseloads down. Second, it could be that the approach needs to be updated, for example, with training for staff on techniques or more involvement of family members. It is important to remember that MHSA only provides an additional 15% to the mental health budget, so counties must decide how will it best be used to have an impact on the whole system.
- Survival is a key concern for many people with mental illness. Some people on Medi-Cal receive only $9 per month for food stamps, which leads to a very poor diet. It would be good to target this. People who are covered by both Medicare and Medi-Cal (Medi-Medi) may have a prohibitive Share-of-Cost from Medi-Cal for their medications, which does not leave them enough to survive.
  - **DMH Response (CH):** The Medicare Modernization Act will change prescription coverage in 2006. For people who are in the Medi-Medi category, this is a scary time. There will be radical changes with a small window to sign up for plans. Consumers and families need to pay attention to this issue.
- Is it correct that youngsters who have insurance but are underserved will receive services under this act?
  - **DMH Response (CH):** People who have insurance but not adequate care can be included, but it becomes a matter of priority-setting. DMH policy states that priority should be the unserved or so severely underserved they are at risk for negative outcomes. If counties have other priorities, they need to explain why.

Cultural Competence

- The document needs to go further with references to tribal communities, especially for urban populations. Such language already exists. “Reservations” is not the correct term in California.

- It is challenging in some places where there are historical disconnects between tribes and county planning processes. There are several tribal communities in the State that have felt left out of the process.
- Explore the role of the presidential order on tribal consultation to federally qualified tribes.
- The initial statement about cultural competence is much stronger than it is in the requirements. Take a hard look at the wording.
- How will DMH hold counties accountable for cultural competence?
    - **DMH Response (CH):** This is hard to address. At minimum, reducing cultural disparities has to be in a county's plan and there must be strategies to accomplish this.

Education and Training

- In terms of workforce development, the Asian community in Los Angeles is looking at a model of care with parent, family and consumer advocates, but not enough people are trained to provide this.
    - **DMH Response (CH):** The workgroup on Education and Training will be June 16. Information in preparation of that workgroup will be posted on the DMH website next week.
- Will this funding impact the September 2005 class of incoming students in professional training?
    - **DMH Response (CH):** It might. DMH is proposing some short-term strategies as well as a five-year strategy.
- Can counties use System Capacity money for Workforce Development?
    - **DMH Response (CH):** Yes, and counties might also use one-time funds.
- There are limited funds, but outreach and engagement to the school system is critical. Schools are the first line of defense to see children and their families, and they see children at a very young age. As far as mental health services on school campuses, California ranks 50th in the nation with a very poor provider/student ratio. Equity and access is important for all school districts so all schools know how to access services for students with mental health needs.
    - **DMH Response (CH):** DMH is trying to give some state funds to other state departments to enhance services statewide. For example, if the Governor approves the proposal, MHSA will provide funds to the Department of Education to develop materials on early signs of potential suicide and what to do to.
    - **Stakeholder Response:** Teacher training programs already get information about suicide and about how to manage physical health problems in students. But teachers are not trained to recognize the signs for a range of mental health problems. Do not focus just on suicide but across the spectrum. McGraw-Hill has a textbook on the spectrum of mental health issues.

Specific Strategies

- The Santa Fe Social Club encourages consumers to go out and not isolate. It has helped people so they can improve.

- Health education will help people with the recovery model.
- Please provide clarification of Page 26 regarding CSOC service strategies, including on and offsite services for primary care clinics, and integration for mental health and substance abuse or mental health and primary care.
- The Asian community is concerned about whether MHSA requires AB 2034.
    - **DMH Response (CH):** DMH has said what needs to be in the plan but has not specified the strategies to be used in implementing the plans.

Age Groups

- In terms of services for adopted and foster youth for children across county lines: the funding is coming out in different components and still requires coordination between counties. Can this be made easier for counties and therefore children?
    - **DMH Response (CH):** Out-of-county issues are among the most difficult the mental health system has to face. Who is responsible for the person must be clear. This is one of the assets that managed care provided. There are fewer arguments. However, the mechanics of working across counties are the hardest to solve. DMH will begin asking counties to describe what they are doing. For adoption assistance, DMH has asked the Department of Health Services to modify their database to show where the adopted child is now living.
- Transition-age youth appear to be between target populations. Do they use the Children's System of Care (CSOC) or system of care for adults? Is there one way to go or another?
    - **DMH Response (CH):** MHSA will struggle with transition-age youth and where they belong for a while.
- Respite care had been listed as a separate category in the children's section. Now it is a subcategory under crisis. Please have it as its own separate category again, in all four age groups. Respite care needs to be available and included across the board. It belongs in crisis as well as in every single aspect for all age groups.

Full Service Partnerships

- Our county is getting resistance to the 50% allocation for Full Service Partnerships. Why is the Department requiring that and why is it consistent with MHSA?
    - **DMH Response (CH):** DMH believes Full Service Partnerships are the best way to move people toward recovery and wellness. Everyone should have access to these types of partnerships, but there is not enough funding for everyone, so this is a start. DMH wants to show what it would be like if Full Service Partnerships were available to all and thinks it is completely consistent with the Act.
- The most important change in this draft is the Full Service Partnerships and 24/7 assistance. In some counties, if they implemented just that, the county would use its entire allocation serving a very small number of people. What if the community planning process leads a county to a very different conclusion about what is needed?
    - **DMH Response (CH):** DMH has tried to balance the need to tell a statewide story and local needs. There must be statewide standards. It is challenging that

counties are setting their goals without knowing the final State requirements. There are some options for telling us what counties are doing that is different from the State priorities.

- The new Full Service Partnerships for the currently unserved people will provide them with a higher level of care than the people who are already in the system receiving inadequate services. The ethical implications of this need to be considered.

Expectations

- How will DMH address the issue of unrealistic expectations? This is especially an issue in terms of outreach, in which MHSA efforts are raising expectations and may not have sufficient funding for enough services to meet all the needs. It is not possible to transform the system immediately and it is important to manage expectations.
  - **DMH Response (CH):** This is the primary struggle for this process of development. Initially everyone went out to promote enthusiasm, and now many are realizing that MHSA will not provide a lot of money. The funding designated for CSS services is only $350 million. How much can be done with so little while counties are making cuts? It is a balancing act of keeping dreams high given the limited amount of money.
- Ethnic communities are concerned about outreach and engagement. This is a tremendous opportunity to bring people to the table. But once people are engaged, they will expect to be served. These activities need to be very purposeful. It is vital that this opportunity not end up being frustrating and alienating.

Budget

- Is the planning estimate an annual figure? What happens to the first year's funding? Do counties lose half of it?
  - **DMH Response (CH):** Yes, it is an annual amount and will go up 1% in 2006/07 and another 6% in 2007/08. Counties can receive up to the annual maximum prorated. They can also get up to 25% for pre-implementation activities, 5% for additional planning; and the entire amount if they can justify one-time expenses.
- Will the other components adhere to the same percentages?
  - **DMH Response (CH):** DMH does not know yet.

Positive Feedback

- The Readers Guide is great.
- Changes to the funding formula are good, especially including self-sufficiency.
- The work done by DMH is praiseworthy; we appreciate the massiveness of the tasks and the pressure.

D. Written Feedback on CSS Plan Requirements Revised Draft

After Ms. Hood finished her presentation and responded to questions, the stakeholders provided written feedback concerning the DRAFT CSS Plan Requirements, following the structure of the document. In addition to requesting specific feedback for each section, stakeholders were also asked to provide any other comments about the document they might have as well as comments about positive changes. These comments were written by stakeholders on large sheets of paper.

Part I, Sections I and II: County/Community Public Planning Process and Plan Review

Outreach and Engagement

- Please define the difference between outreach, engagement and early intervention.
- Rural county funding should be amended to account for the higher cost of transportation to bring consumers to reach meetings.
- What has worked for outreach in other counties? Provide counties with evidence-based practices.
- Page 17: "Using available local data." Underserved and unserved populations are not usually represented in "local data." Native Americans are often not represented in county data, making Native Americans (80,000 in the San Francisco Bay Area alone) invisible. Active and effective outreach needs to go beyond relying on county data. Community-based organizations like Native American Health Centers have a better pulse on the Native American population than county data.
- Hold more meetings close to home in the community with easy access to members.
- Conduct more community outreach and spread the word to really involve parents and children.
- Need more advocates involved to get to the communities in doing outreach. Bring them to the table to receive services.
- Recognize that schools are a wonderful site for outreach. They are already doing it, often at Healthy Start community outreach and student support sites. School counselors and mental health school workers are often first to see and notice behaviors of concern. School districts should be part of the outreach and engagement funding.

County Planning Accountability

- How does planning become transformative when the county uses old planning to decide the direction of MHSA funding?
- This document seems to reflect a distrust of the individual counties. DMH needs to trust the process to encourage the most innovative solutions to achieve MHSA goals.
- The brevity of the report from counties with no "conditions" is a concern. A distinction needs to be drawn between being able to write a good plan and actually

executing said plan well. There needs to be good documentation of the process as it actually happened. In exemplary circumstances, this could be a resource for others.

- There needs to be a designated contact/process at DMH for clients and family members who want to "grieve" that their county is not implementing the stakeholders process according to approved plan-to-plan.
- Pages 9 – 11: How does DMH hold the counties accountable for true family and client involvement instead of just tokenism? Our county's planning process is so top-down it is a barrier to give meaningful input.
- How do DMH and the counties ensure that the people's voices – those of clients, the consumers, the family members – are really heard?
- Counties should provide transportation for clients to consumer councils and other meetings or programs.

Training

- Page 11: Training is not being provided equally to family and consumers. In Alameda County, many planning meetings are being held in a building not accessible by public transportation.
- Peer-support training should be done by peers, for example the California Network of Mental Health Clients' Office of Self-Help.
- There is concern about the competence of some counties to mount training or even to judge who should train or what is adequate content. Is the county training sufficiently informed and informing on practice possibilities (i.e., how AB 2034 works) and transformation of services? There needs to be a commitment from DMH to work with counties on their training needs and content.
- Training and education is 10% of MHSA funding and CSS 50%. Please clarify who decides which MHSA funding the program or service is best funded from. What if both apply?
- Need to invest in developing client capacities in client-staffed agencies, just as investments are made in professional staff training.
- Please state whether there will be focus group facilitator training, and whether it will be county-specific or regional. State when the focus groups should start.

Client and Family Member Empowerment

- If real clients headed each state and/or county chair or top position, what would the CSS three-year plan look like?
- Including client advocates in the planning process is pointless without clients in the decision-making process.
- Playing clients like puppets for the purpose of the "planning process" is pointless! Clients are "played out" of the real decisions.
- The system will continue to segregate, stigmatize, alienate and dis-empower clients, even if they "collaborate," "integrate," "fabricate," but do not ever mandate client representatives in professional occupations. Client empowerment equals client-driven and client-staffed agencies.

Cultural Competence

- Do not use the terminology "embedding cultural competence." Be up front that the MHSA is about eliminating ethnic disparities and "doing" cultural competence.
- Cultural competence will ultimately mean nothing so long as stigma exists.
- All meetings, both at the State and local level, need to be fully accessible in terms of the meeting rooms and buildings and electronic formats (CDs) whenever paper copies are provided, for at least a few of those who are deaf or blind.
- A specific plan for how cultural competence will be achieved and how ethnic minorities will be recruited to be involved in the entire process needs to be included.

Transition-Age Youth (16 – 25)

- Clarify the definition of transition-age youth.
- Treating mental illness properly requires early detection and treatment. High schools are natural touch-points for early detection.
- What are the various counties doing to implement programs where transition-age youth are participating in their own recovery?
- Address how to engage transition-age youth since they do not fit with children's mental health or with adult mental health.

Mental Health Boards

- What happened to the Statewide Mental Health Board? How are local boards being supported in this process? How can they be part of the process, without representatives?
- I thought California had an Association of Mental Health Boards: where are they in this process? Why are they not involved in the COEC, if local boards are the local authority?
- What is the adopted plan that the Mental Health Board has also to comment on? The initial draft plan is what the Mental Health Board has to have the public hearing on.
- Hold a retreat for all Mental Health Boards in relation to cultural competence. There is a lack of understanding of Native Americans. MHSA funding is critical for this, especially for Mendocino County.

Improving MHSA Process and Service Delivery over Time

- Will provision be made for waiving plan requirements during the three years of funding to reflect new knowledge of how to better allocate resources?
- There is a gap between measuring selected client outcomes over time and using this information to change or improve service programs. How will these data be analyzed and shared down to the program level where changes can be made? How will the effects of services be distinguished from all other causes of client changes?

Payor Issues

- Page 9: in the statement "A transformed mental health system will require new and innovative…" add "*other public payors such as Medicare*" or add "*any payor, public or private.*" Individuals accessing MHSA funds and services should have open access to new innovative services, treatments and medications, regardless of insurance (Medi-Cal, Medicare, private, etc.).
- Need some type of nexus between public and provide health plans for mental illness.

Part II, Section I: Program Expenditure Plan Requirements, Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

General Issues

Client and Family Member Empowerment

- How can there be a system change, client-driven programs and client representation in the professional arena when clients often face barriers such as criminal charges that block them out of the workplace?
- MHSA should implement a statute that is client-friendly to help mental health clients with criminal histories overcome the barrier to become a professional in the system that has disempowered them.
- Please plan to place clients and family members at all points of all planning processes.
- Add wellness and recovery elements.
- Add peer-support and employment for family and consumers along with employment.
- Clients would be the most influential trainers. It would be a great way to promote empowerment and would provide paid opportunities and workforce development.
- The planning processes have become extremely complicated and are alienating consumers and family members who DMH is trying to include.
- This process is "business as usual": a top down strategy. DMH is developing the MHSA with layers of bureaucracy, which are limiting the creative input of all the stakeholder groups which DMH claims to value.
- The core issue is not attitude but the social death sentence. How can behavioral management be removed from people's lives?

Cultural Competence

- Need stronger support for emergent multicultural perspectives. For example, the Coalition for Justice and Accountability (San Jose multicultural "police shootings" group) is a Santa Clara County stakeholder interested in dialogue with employment preparation services (EPS) from the community.

- Native Americans, Asians, mental health clients, etc. are not the people who need to learn cultural competence. It is the service systems and providers who need this training.
- Thank you for including Native Americans in the document. However, California actually has rancherias and only two reservations. Also large numbers of Native Americans live in the cities and counties of California. These urban populations will be missed in language such as "reservation," "rancheria" or "tribal organizations." Urban Indian Centers or Indian non-profit or community-based organizations need to be included in the language to not miss the larger Native American population in the cities and counties. Urban Indians' high numbers are not represented in "local county data." The experts on urban Indian populations need to be identified so urban Indians are represented.
- Please clarify whether DMH is requiring that counties update their Cultural Competence Plan with non-Medi-Cal population data. Clarify whether DMH wants new numbers only or a completely re-written plan.

Outcomes

- Require that CSS plans describe how reduction in institutionalized placements will be achieved (i.e., alternative programs, expansion of supportive housing, specific strategies and services to prevent need to place in locked setting).
- Consumer- and family-run programs are less sophisticated in terms of being able to participate in the outcomes tracking systems. As a result, counties may try to shy away from working with them.
- How will the public be reassured that their vote was worth anything if the first services are not directed to the homeless, jailed, hospitalized and emergency clients?

Education and Training

- Counties need to provide timelines on training.
- Hiring clients and family members to do trainings is critical.
- Educate the general public to help reduce stigma. Promote awareness in the face of mental illness.

Small County Issues

- Rural and small counties are again getting short-changed. They do not have resources now. There is not enough money to develop, sustain and create what citizens are asking for.

Age Groups

Children & Youth

- Add "*and/or out-of-area"* to between "out-of-home" and "placement" in "For children, youth and some transition-age youth, inability to be in a mainstream school environment, school failure, hospitalization, peer and family problems, out-of-home placement, and involvement in the child welfare and juvenile justice system."
- Families should not need to fail before they get the help they need. Make it easier to get respite care.
- Require input from families and caregivers.
- Include meetings and input from schools in the communities.
- Schools should not be overlooked as a stakeholder and partner in identifying children and families who would benefit from outreach and engagement.
- Teachers and administrators need education about early identification, prevention of substance abuse and early intervention programs.
- Require education in schools for students to reduce stigma about what mental illness is.

Transition-Age Youth (16 – 25)

- Address the chasm which transition-age youth fall into when they turn 18 and graduate: they are often turned out onto the streets.
- Need emergency fund availability for youth homelessness.
- Recognize the fact that it is very difficult for transition-age youth to accept that they are mentally ill. Need strategies to address this, including funding for education and outreach.
- Hold forum for youth issues, to be addressed by youth in need as part of the stakeholder process.
- Need strategies to address younger siblings of transition-age youth.

Adults

- Add "*and consumer and family member employment*" to "expand peer support."
- Add direction on support services for transition from institutions, jail, etc. into the community: are these populations being captured in this program?
- Education-based recovery needs client-driven approach backed by community colleges rather than "supported education" counselor and treatment-driven approach.
- No person should be "diagnosed" as mentally ill until s/he has been assessed and treated or offered meaningful treatment for post-traumatic stress disorder (PTSD), the primary illness.
- Please clarify whether the adult developmentally disabled population are included in the MHSA and have access to wellness and recovery-based services. Please clarify whether they will have access to services to increase independence and not rely on institutionalized care.

Older Adults

- Require that counties focus on the special needs of older adults with mental illness.

Part II, Section II: Program Expenditure Plan Requirements, Analyzing Mental Health Needs in the Community

General Issues

Definitions

- Page 16: Underserved and inappropriately served: repeat last seven lines from previous section: "frequently, unserved individuals/families are part of racial or ethnic populations…" as this statement applies to the underserved and inappropriately served also.
- Please provide consistency in the terms unserved, underserved and inappropriately served.
- Clarify definition of unserved: if individuals are incarcerated in jail and/or juvenile facilities and receive some mental health treatment but are not connected with community services, are they unserved or underserved upon release to the community?
- Clarify "legal status" in terms of MHSA, including immigration, etc.
- Clarify how the numbers of undocumented individuals were included in priority or county needs.

Services and Supports

- Page 16: line 11: IMD: Why are the people not receiving services that would allow them to move on, such as education?
- Explain how PTSD treatment will be integrated into MHSA programs and services.
- It is important that consumers are not placed out-of-county in IMDs and Board and Care facilities. They should be given in-home supports and supported housing to be able to remain in their community. This could provide a better quality of life for the consumers.
- If Full Service Partnerships require the client to sign a contract, then it is involuntary treatment.
- Consumer and family-run programs are less sophisticated in terms of being able to participate in the outcomes tracking systems. They need support so counties don't shy away from them.

Other

- Page 15: how can counties go about helping the unserved addressing their ethnicity and their culture?

- Clinical competency is more than "evidence-based practices." It includes the individual clinician's skills.
- Describe how people within the community who have "mysteriously" been left out of the process can introduce and possibly implement a new idea or program with MHSA funds.

Age Groups

Children & Youth

- Require comprehensive transition plans for children living family-style (i.e., with grandparents or other relatives in kinship care) which is similar to that provided by foster care.
- Page 16: definition of underserved and inappropriately served children should include children who have emotional or behavioral disorders and learning disabilities or developmental delays.

Transition-Age Youth (16 – 25)

- Page 17: definition of underserved or inappropriately served transition-age youth should include those who do not have a comprehensive plan for transitioning from family-style living to community and independent living.
- Page 32, bullet 3: would it be possible for the counties with family-to-family programs to access MHSA funds?
- Transition-age youth should have a catch-all treatment plan prepared for them before they reach 18. This should include counseling for daily living skills (housing, job search, banking knowledge, transportation, etc.).
- Families of transition-age youth need to be assured that there is good and timely help available for their family member needing services.

Part I Section III: Program Expenditure Plan Requirements, Identifying Initial Populations for Full Service Partnerships

General Issues

Consumer and Family Member Empowerment

- Clients cannot participate if they cannot come to the meetings. Reimbursements are largely not being offered. Therefore the client opinions are the most unexpressed or attended to. Who is the system for?
- The draft needs to reflect how counties will hire consumers and family members in the mental health systems and the communities.
- Hire clients for crisis teams and crisis housing staff.
- The counties will need training on how to hire consumers and family members.

Other

- Use language that allows for exceptions to "Full Service Partnerships" for funding where extenuating circumstances may exist (in local agencies and varying counties).
- When clients are hospitalized, their medical health needs are ignored. Indeed the psychiatric hospital is told to only address their psychiatric needs.
- Please explain why only small counties were given the exemption to use community partners for 24/7 response, rather than including counties that have trouble recruiting staff.
- Full Service Partnerships: please define and explain enforcement of reasonable workloads as required or envisioned.
- In terms of Full Service Partnerships, providing "all needed services or benefits" to clients seems excessive. Since when did mental health become responsible for physical health, housing, jobs, social supports, etc.?

Age Groups

Children & Youth

- Add phrasing related to serving youth in schools who are not yet identified as special education. This could be crisis funding or prevention/early intervention.
- Add "*and adopted youth*" before "placed out-of-county" so that counties understand it also includes that population.
- Please clarify whether the Full Service Partnerships for children are limited to Wraparound. If so, Sacramento County would be limited to the amount of foster care funding available to add children to their program. Local mental health does not control that.
- It is a limiting factor to have only one funding mechanism to address Full Service Partnerships with children. Clarify whether the fact that the MHSA references Welfare and Institutions (W&I) 18250 necessarily precludes another kind of funding.
- Pages 21-22: "Services should include the ability of PSCs… including 24/7." Please clarify what is meant by that. If "responds to" means "advocates for," "take direction from" or "report personal medical information to," this section should be re-written so that the client (or, to the extent required by law, the family or caregiver of children or youth) should be the only one advocated for, and should be the only one who directs services and accesses confidential personal and medical records. If this is the meaning of those phrases, then landlords, law enforcement, neighbors, family friends and others should be explicitly banned from the list of people to whom the PSC/case manager must have the ability to "respond to" 24/7. Otherwise, widespread coercion will be written into the plan requirements.

Transition-Age Youth (16 – 25)

- Thank you for including mention of transition-age youth who have experienced first episodes of major mental illness.

- There needs to be a free-flowing services system for youth to go to for services when they transition from children's to adult services.
- Why does SAMHSA define transition-age youth as 14-25 while MHSA uses 16-25 years?

Adults

Full Service Partnerships

- There is a lack of understanding in the use of only 50% getting full service treatment plans.
- Full Service Partnerships requirements unfairly allocate over 50% of MHSA funds to a small percentage of the county's mentally ill population. In our county, if these funds are equally distributed among the four age groups, less than 10 percent of these populations (about 22 people) will receive these services. This is wrong and not in the spirit of MHSA. If the Full Service Partnership requirement had been spelled out to the voting public, Proposition 63 would never have passed. Please reconsider this requirement.
- The full service programs need to outreach to persons on 5150 holds, who may want the services. This will lead to better outcomes if the person wants the services.
- Since it is impossible to provide Full Service Partnerships for isolated rural clients and Native American tribes, it is unfair to therefore provide nothing for them.
- Please clarify whether a client who does not voluntarily want full service therefore gets nothing, not even the help the client wants.
- Get rid of the term "case manager." Clients are people, not cases. This is insulting and stigmatizing.

Law Enforcement

- Page 30: "Integrated services with law enforcement, probation and courts…": coercing or "leveraging" a person into a program changes the nature of the program itself for that person, staff and other clients in the program.
- There needs to be a clear statement in the requirement that MHSA dollars cannot be spent on courts or jail programs.
- Peer-run, person-centered outreach is a critical way to link people with an array of truly voluntary, self-directed services and supports. On the other hand, partnering with law enforcement alters the overall effect of an outreach worker's first contract with a homeless person. This approach has failed miserably in San Francisco. As the primary enforcers of anti-homeless "quality of life" policies, the San Francisco Police Department has a well-established reputation for constant harassment, brutality, ticketing, arrests and involuntary hospitalization of homeless people, as well as confiscating their belongings and evicting them from makeshift encampments and squats. The SFPD's recent media makeover as "kinder and gentler" partners in outreach efforts has only served to mask their ongoing abuses of homeless people. "Partnerships" with law enforcement will at best discourage people from accessing services and at worst coerce or force people into programs or respond with unnecessary force.

Older Adults

- Older adults need more involvement and no involuntary commitment by families and then thrown away. They need mentors.

Part II, Section IV: Program Expenditure Plan Requirements, Identifying Strategies

General Issues

Services, Supports and Strategies

- Add crisis residential programs to serve as an alternative to hospital-based acute care settings to crisis system, across age groups. This is not housing.
- Consumers should have supported housing in good neighborhoods away from drugs and alcohol in order to promote recovery.
- Peer services must be adequately funded, not bare bones only.
- There needs to be more group counseling with group facilitators to help educate the mentally ill on how to receive help and how to help themselves.
- Respite care should stay in the crisis category but should also be put as a separate bullet in the children, transition-age youth, adult and older adult categories.
- Transformative strategies need to include developing alternatives to high-cost, non-Medi-Cal-eligible 24-hour care settings to redirection to recovery.
- There is nothing in the documents about PAT therapy. This is a therapy that will work for all age groups.
- Respite care is needed in all crisis categories.
- Need easy access, i.e., telephone numbers for families in a crisis, as well as respite, resource funding for housing or rental assistance.
- Ideas should not be limited to AB 34, but all ideas should be included.
- Medication algorithms are not a best practice.

Service Integration

- Add "*Integrate medical and mental health services*" to all age groups. Also add services in primary care clinics.
- Please clarify "integrated both services": explain whether it references medical and mental health and/or mental health and substance abuse.
- Please clarify the issue of primary care clinics and on- versus off-site services. Primary care clinics often serve clients offsite as well, in hospitals, jails, nursing homes, etc. for both medical and mental health services.
- Not every service or support needs to come from mental health/behavioral health systems. Clients and family members need a program to exit services without feeling dropped or kicked out.

Outcomes

- There needs to be a priority on an outcome of reducing out-of-county placements.
- Please explain how DMH will measure and code respect, hope, personal empowerment, etc. These are values, not observable behaviors.
- Having providers collect statistics is a conflict of interest. They are writing their own grades! Devise statistics and outcomes reports that are filled out by clients reporting satisfaction.
- There may be a problem in proving the impact of early intervention programs. While these may ultimately contribute to a transformed system, it might be hard demonstrating their immediate outcome.

Full Service Partnerships

- Please define more clearly Full Service Partnerships and system development.
- List other examples of Full Service Partnerships, such as community residential treatment system, other program initiatives from W&I Code program initiative section.
- Please confirm that 50% of funds are to be used for certain types of programs.

Staffing and Program Requirements

- Please clarify whether there will be a certification or licensure requirement for an organization or agency to be able to provide and be reimbursed for mental health services to clients.
- Provide specific caseload standards for PSC/case manager so that workers are able to provide sufficient attention.

Other

- Native Americans have developed their own system of care in some counties. Trying to access or honor these indigenous systems of care in the outreach will be missed by going only to the county for outreach rather than contracting with Native American organizations.
- Perhaps MHSA principles should be applied to Medi-Cal services. It would be useful to change Medi-Cal so that it could be responsive and creative in meeting the needs of the individual. Many services that help are not billable.
- Page 23 and Page 42 #2: Please clarify whether expanding services is acceptable and if so, under what conditions (i.e., serving new populations or people in different area) it is or is not acceptable.
- Include more families and caregivers.

Age Groups

Children & Youth

Schools

- Page 26: "Cultural and gender-sensitive outreach and screening services at schools… which proactively reach children who may have….immediate access to mental health services when needed" and "services and supports in school…": these are dangerous and ill-advised strategies that are inherently coercive resulting in labeling, stigma, and discrimination, and likely social segregation and humiliation of children and youth in a school setting. They will also likely lead to over-diagnosis, unnecessary and inappropriate medication and dangerous side effects. Screening of children in schools is dangerous and will cause lifetimes of unnecessary harm.
- Please clarify whether services can be delivered within the school or educational setting.
- Please make sure that public schools are included in the distribution of funds, in particular, with school mental health workers providing outreach, screening and identifying strategies.
- Do not forget the credentialed mental health workers on public school campuses. They are the gatekeepers for mental health services and have been trained to understand mental health issues as well as the school system.

Other

- Page 25: MHSA requires mental health services provided to children and youth to be part of the CSOC. Please clarify how supplantation language may or may not play a part in providing a CSOC when there is not money in the budget for CSOC.
- Page 26: "Child/Youth peer mentoring": Thank you for adding "Youth involvement in planning and service development, including youth previously involved in juvenile justice settings and out-of-home placement" as well as including gay, lesbian, bisexual, transgender youth diagnosed with SED.
- Thank you for including "integrated services and supports for children/youth and their families with co-occurring mental health and substance use disorders."
- Include information about adequate quality residential treatment for children and adolescents, including runaways so they do not have to be placed far from their families out-of-state.
- Page 29: transportation: the language of "insurance" needs to be added, not just the acquisition of driver's license.

Adults

- People need to feel love and joy and feel good about themselves in a healthy way.
- If clients cannot meet and learn to work together, they cannot offer one-another peer support, form groups to help one-another and help each other become stronger. Consumers need meetings funded for them to meet and solve problems.
- Create more clubhouses or similar places in San Bernardino County.

- Increase the staffing of employees in the clubhouses.
- Lift the limits on prescriptions per month.
- There is a need for some place for consumers and family members to learn where to go and how to navigate the local mental health system. Consumers can benefit from a program in which a peer can guide the way and tie new and old programs together (i.e. consumer affairs office, peer mentors will have graduated from programs, etc.).

Part II, Section V: Program Expenditure Plan Requirements, Assessing Capacity

Contractor Assessment

- Contractors of county mental health services should be assessed for their capacity as well as what relates to performance measures. The money trail should be transparent.
- Ask county departments of mental health to assess community providers, not just county contract providers. It will help with meeting the needs of underserved age groups.
- Community-based organizations or contractors of mental health services need to be assessed for their capacity separately or in some narrative way provided by the county's plan.
- In Letter 05-02, page 2, target population is 200% of poverty with some additions or adjustments. Page 38, #2 of Program and Expenditures Requirements, refers to total population for comparison of ethnic and cultural match between providers and the county total population. Does this mean total population or total population in poverty or total population that is target for the plan?

Staff Training

- Page 38: Draft acknowledges need for assessment of staff training. But there are no specific ways or places in the three-year plan for counties to prioritize and develop strategies to address training needs.
- The requirement for assessing staff training needs is not adequate. It only addresses recovery and wellness training. Other training needs should be identified and assessed by the county.

Other

- By creating some kind of connection service for transition-age youth, counties may be able to identify and treat them when and if they need services as an adult.
- Provide low-cost hand-outs for everyone to take with them into the community so they can constantly represent MHSA by giving and getting contact information and initiating follow-up to invite consumers to workgroups.

Part II, Sections VI and VII: Program Expenditure Plan Requirements, Developing Workplans with Timeframes and Developing Budget Requests

Workplans

- Provide guidance on the length of the plan.
- Reduce the complex nature of the plans required for each age group, i.e. three subgroup plans for each age group.
- Include options to allow jail diversion as part of plan.

Budgets

- The amount of money available to most counties is not adequate to transform the mental health system.
- Please explain why a maximum amount was allocated rather than a minimum, which would have allowed each county to aim for more.
- Please clarify whether small counties can also receive one-time funds to begin to implement plan.
- By pro-rating MHSA funds during the 2005-2006 year to the counties, DMH is causing the counties to move too quickly and to therefore get it wrong the first time around. Counties should be able to get their full amount, even if the three-year plan starts at different times.
- Provide more information about impact on Maintenance of Effort, over- and under-equity counties and restrictions on counties who transfer money from their mental health trust fund.
- Page 9: Medi-Cal reimbursement: make explicit that any MHSA funding used as Medi-Cal match must be for services that meet MHSA standards.
- Please explain the DMH position on counties who transfer from the mental health trust fund and whether this will affect funding.

Children & Youth

- Page 42: Required Exhibits: Exhibit 1.g.: Full Service Partnership Workplan, II. Strategies to be Developed or Expanded, should read, "Describe how strategies will be used to meet the service needs for individuals residing out-of-county *or for foster or adopted youth who reside in your county but are under the jurisdiction of another county*."
- Page 44: Exhibit 2: 1.g.: "Describe how strategies…. residing out-of-county *or for foster or adopted youth who reside in your county but are under the jurisdiction of another county*."
- Encourage the coordination of funds and services at the state level using the California Department of Education, Learning Support Division.
- Ensure that equity and access to funds and services are considerations as they apply to all public school systems.

Other

- While DMH comments about AB 2034 are appreciated, it still appears that Medi-Cal billing will control how services are offered.
- Give counties more flexibility, control and decision-making.

Other Comments

General Issues

Cultural Competence

- There is a large Armenian immigrant population in Los Angeles who have no services in their native language. There is an increase in suicides, gangs, substance abuse and mental illness in its various forms and a need for mental health education, parenting training, outreach and information about services. It is estimated that about 600,000 Armenians live in California and 400,000 of them live in Los Angeles County and southern California. In Los Angeles County, they are concentrated in Hollywood, Glendale, San Fernando and San Gabriel Valleys.
- Need competitive salaries to bring more bi-lingual providers, i.e., therapists, case managers and parent advocates.

Definitions and Clarifications

- Please clarify whether community members can refer potential consumers to a referral or clearing agency to direct them to resources.
- 24/7 coverage by a "person known to the client/family" is extremely burdensome.
- It is difficult to determine whether what underserved populations receive is what they want. They may only want medication clinic services, for example.
- Please clarify whether non-small counties can use community-based organizations to provide 24/7 response capability.

Accountability, Outcomes and Quality Improvement

- Allow county-developed community monitors to oversee spending of MHSA dollars, not county monitors, to allow counties to be creative, stepping outside the boundaries of state regulations.
- Need to report outcomes to include race, economic category, and language at home.
- Clarify what it means to follow the progress and measurement.
- Please clarify what type of monitoring will there be for counties.
- Please keep subjective outcome measures "do-able" and realistic.
- Quality improvement needs an explicit placeholder mention as a process that will be developed.

Client and Family Member Empowerment

- When people say they are ready to work, they are ready. They should be able to go to work and test the waters, without fear or risk of losing their benefits.
- What happens to the people with the Client Network who are no longer directors: can they stay involved on committees and meetings like this?

Priorities

- People need to have access to treatment at the first sign of mental illness, regardless of ability to pay, regardless of whether they have been diagnosed by a physician, etc.
- Add to five fundamental concepts: promote voluntary alternatives to involuntary 24-hour care settings, thereby reducing involuntary treatment, incarceration based on psychosocial rehabilitation services (PSR).
- Remember and take care of the people who have jobs but no insurance. These people need services and help so that they do not have to quit their jobs to qualify for services.
- People whose income is too high for eligibility and too low for self-pay will fall through the cracks.

Complexity

- There is too much numerical complexity. There are three types of system funding and four age groups, which equals twelve county plans per county. This is too complex.
- Asking counties to make up or guess at numbers of clients served in each quarter of each year is pointless. They can only be guesses. Simply ask for a number.

Small Counties

- It is good that DMH recognizes the needs of small counties. Between everyday operations and the requirements of MHSA, small county staff really struggle to do the work. MHSA requires a lot of extra time, but so far, our county has been unable to hire people to help with the workload.
- Performance measures will be a huge burden for small counties to implement with limited resources.

Other

- Launch a statewide stigma elimination media campaign.
- Develop a MHSA “problem resolution process.”
- Put county plans-to-plan on DMH website.
- Host stakeholder meetings closer to Orange County.
- Services from Merced County Child and Adult DMH are good.

Age Groups

Children & Youth

- Technical Assistance Document 3, Page 9.3.: Amend to add "*services are coordinated and delivered through linkages with schools*."
- Technical Assistance Document 3, Page 10.4.: Amend to add "*schools*" between home and community.
- Children who are not in DMH and DCFS are falling through the cracks.
- Please keep CSOC and Wraparound values and principles in the document. With the dissolution of CSOC, these values will be diluted.

Transition-Age Youth (16 – 25)

- Please clarify what target population definitions (CSOC or Adult System of Care) apply to transition-age youth and are mandated programs for addressing in the plan? Explain how the definition applies for a first psychiatric break.
- Streamline the process for accessing services and resources for transition-age youth to allow for more expeditious provision of services.

Adults

- Throughout the document, there are references to involving clients and family members equally. Each situation should be reviewed as to how much family involvement should occur based on whether the adult client wants family involvement.

Older Adults

- Please clarify why the draft defines a fifth group as transitional older adults (50-59) in some areas and ignores them in others. This confuses the issue unnecessarily.

Positive Changes to the Revised Draft CSS Requirements

- Wow! Bravo! For all the reforms requested by consumers!
- Thank you for attention to the differences of rural and urban problems. The stakeholder process is an important step in the transformation of the mental health system. Thank you for listening to clients and consumers of all races.
- Thank you for including improved requirement to address mental health disparities for race and ethnicity.
- It is good that adult client now defines family.
- The Reader's Guide is a wonderful idea: simple, clear, concise. Do this for the rest of the document.
- Thank you for the statement on Page 2 about voluntary services.
- New language on involuntary treatment is thrilling. Please ensure that no money goes toward involuntary treatment.

- Good job!

E. Involuntary Services and MHSA

Ms. Hood introduced Dr. Stephen Mayberg, Director of the California Department of Mental Health. She set his presentation in context, reminding people about the different components of MHSA, starting with Community Services and Supports. In terms of CSS, DMH developed a first draft for which it received substantial feedback. The draft was revised and additional input is being solicited now. The most controversial issue in the document has been whether MHSA can be used to fund involuntary services.

Stephen Mayberg, Ph.D. Comments

Dr. Mayberg discussed some of the lessons of the first six months of MHSA planning. DMH learned that this work has been much harder than anticipated. Stakeholders all agree on values and vision, but the details to achieve the mission have been much harder to work out.

Dr. Mayberg expressed understanding that when people talk about the MHSA, they are talking about their hopes and dreams. Because these are intensely personal, there is an intensity, urgency and compelling nature to their feedback. It has been touching, moving and overwhelming. People want the system to be better and many have had experiences that have been painful, for a variety of reasons. The Department is hearing from many voices, both old ones and new ones. The amount of information has been overwhelming at times. Listening is difficult for everyone. Coming to agreement is difficult. Together, stakeholders are moving toward accepting that people have different points of view. But everyone is committed to the process and the process is the beginning of transformation. Everyone is learning things they never understood before. This process is not time-limited, but will be ongoing. It is important to realize that it cannot all be done at once.

Dr. Mayberg has intentionally provoked questions about critical issues that needed to be raised, including the question about involuntary services. Stakeholders are not as far apart on this issue as they think. Stakeholders have revisited the AB 1421 debate, with some rancor remaining from the single issue that has split the mental health coalition over the years.

The primary principle that drives what DMH does is that services need to be client- and family-driven. It is about people, not services. Together, the Department and stakeholders will work to build a system based on the needs of clients and families.

Another DMH core principle is that access has to be equal for everybody. No one should get better or worse services based on gender, ethnicity, age, etc. How services are prioritized is the key question. System capacity is essential.

It is DMH's position that all of the programs developed for MHSA should be voluntary in nature and should be available to anyone regardless of legal status and that MHSA's goal is to reduce involuntary, coercive treatment. MHSA gives us hope and alternatives that will help to move people toward recovery and out of institutions. The intent is to fund expansion or development of voluntary services and programs through MHSA, while people who need involuntary services will still have access to them. Someone who is a conservatee or a participant in a mental health court or in an IMD should have access to MHSA services. For example, the more MHSA programs free up IMD expenditures, the more current funding will be available to be used by counties for their priorities.

We are recommending that MHSA funding not be used for administration of mental health courts or for a stand-alone AB 1421 program. A county can use MHSA funding for services for people who are in a mental health court or in a 1421 program. At the same time, it is important to remember that some people in MHSA programs will sometimes need to be hospitalized. Having to be 5150'ed should not expel a client from MHSA. Already, a small percentage of people who participate in AB 2034 are conservatees. There is a continuum of services, including both voluntary and involuntary and we must recognize this is necessary.

The best services are those that are part of a coordinated system of care. DMH wants each county to have a range of services. Therefore, MHSA will fund Full Service Partnership programs that are primarily voluntary in nature. But someone who is a conservatee, an AB 1421 program member, a referral from juvenile or criminal justice, etc. should not be denied access to those services. Inclusion in MHSA programs may expedite, for example, moving a conservatee from an IMD to the community. It also means that if someone in a voluntary program has an exacerbation of symptoms and needs to be hospitalized, s/he should not be excluded from MHSA services. DMH wants to reduce use of hospitalizations. People say that the conservatee does not have a choice, but is being coerced to participate. DMH hopes they would choose to participate in the MHSA program as a critical step to leaving the IMD.

MHSA only increases the total state mental health budget by 10-15% and there will still be money in realignment funds for involuntary services. If MHSA reduces hospitalization, there will be more money to pay for involuntary services when needed. MHSA does not undo or change existing legislation, but operates in conjunction with them. Most people working in involuntary services are less interested in using MHSA funding for involuntary services than they are concerned that there is no place in the community to release consumers, especially children, to so they can re-engage in their community rather than stay in residential treatment; it would be far better to release him or her to a Full Service Partnership team. System capacity is essential.

Stakeholder Questions and Comments

Coercion/Diversion

- The involuntary system is discriminatory. The choice is taken away from the client. When the consumer is ready to move forward in her/his life, s/he is not allowed to do that. Clients are still stuck with the stigma and closed out of those doors. Integrated services and client empowerment are important. I do not see those doors opening.
  - **DMH Response (Dr. Mayberg (SM)):** Yes, doors open slowly, but the system must change to meet people's needs.
- It is fine for people from the jails to come to self-help groups. They should not be forced to come to self-help groups because people who do not want to be there poison the well. Hospitals and jails need to use their budgets to meet the needs of their population; MHSA money should not be used for jail programs. MHSA is supposed to be community-based.
  - **DMH Response (SM):** This funding is to help people get out of jail, not get to jail. Counties need to be responsive to their communities.
- Too many mentally ill people are in the prisons. Recovery is important. The time to intervene is before they get to prison. If effective programs can help sons and daughters and take years off their incarceration and these programs are not used, that is immoral. Please clarify language. Diversion programs often work.
  - **DMH Response (SM):** Diversion means "use this program or go to jail." Is that choice? I think so. We want to reduce incarcerations.
- Look at W&I Codes about voluntary services. As soon as some conservator says, "I want you to go to that program," it is a problem. Come up with a protocol that can assure that the person really wants to be in a program.
- How will MHSA funding be used? Will it be coercive in nature? Earlier you said people are allowed to say no. If someone says no, under a court order, then where do they go?
  - **DMH Response (SM):** They may end up in jail, IMD or the hospital. There are sometimes consequences to choices.
  - **Stakeholder Response:** This type of coercion is discrimination against the severely mentally ill. There are principles for self-determination from the Client Network.
  - **DMH Response (SM):** There is always a responsibility for the consequences for one's actions or behaviors. Principles of self-determination are important and should be part of the evaluation.
- Is a program that offers a choice between an IMD or a community program fundable by MHSA?
  - **DMH Response (SM):** The goal is to reduce IMDs and to not pay for involuntary programs. For people who have a choice between jail and a program in the community, it is not really voluntary, it is coercive, but they still have a choice. These are goals in conflict: reduction of prison and reduction of IMDs and increase in voluntary treatment.
- Thank you for the most recent draft, because the Client Network has wanted this. Even people under conservatorship have a choice of programs. The responsibility

for choosing to participate in any MHSA-funded program should still reside with the client. You cannot force a person into a voluntary program.
    - **DMH Response (SM):** This is an important point, the legal status is important but should not change program eligibility. Resistance and ambivalence are common and must be dealt with.

Discrimination

- If you cannot change the nature of mental illness, how can you discriminate against one kind of treatment?
    - **DMH Response (SM):** People will need involuntary services and DMH does not want those services to be in jail. The Department believes outreach and engagement is important and sees the importance of having programs where clinicians are involved. The intent is to keep people out of jail, but there still needs to be opportunities for programs that meet the individuals' needs.
- Services should be available for any and all who meet the eligibility requirements regardless of their legal status. They should have a right to those services. It appears DMH is saying that first we are going to try voluntary stuff and then we will have the involuntary services. Start now to provide the needed services. If the right services are provided, MHSA can reduce hospitalization and jail. Do not fund AB 1421 services, but provide access to AB 1421 services for people who need them.
    - **DMH Response (SM):** That is correct.
- MHSA calls for non-discriminatory services. But many of us have family members who have recycled through the system and, at times, have needed non-voluntary services. This interpretation of the MHSA is not consistent with the Act. Please point out the justification for your position. Consumers talk about promises made to them during the election cycle and it seems like this is keeping those promises rather than doing what is right and is in the Act itself.
    - **DMH Response (SM):** The Act is very clear about non-discrimination. AB 1421 says you cannot subsume voluntary into involuntary services. MHSA, AB 1421, and realignment all need to be considered here. A legal opinion is needed to respond to some of these issues. This decision reflects the stakeholder process and legal advice. DMH was not party to promises that were made in the political arena and certainly made no promises itself before MHSA was passed. DMH is now, however, engaged in interpreting the State's obligations now that implementation of the intent and process of the Act is underway.
- Families are worried about creating a two-tiered system, one in which clients receive enhanced services and one in which clients receive more of the "same old same old." Families are encouraged by your words, but are concerned. A large number of NAMI people need to be convinced to join the system. MHSA should allow more outreach to the unwilling.
- Most of the population of California that will be affected by MHSA are not here today. Please clearly state in the CSS Plan Requirements "funding for services for clients no matter what their status in which they entered the program, voluntary or involuntary." Nothing says all services must be voluntary.

- **DMH Response:** DMH needs to clarify this statement. The more stakeholders talk, the clearer it is that there is a lot of agreement. Agreement is moving closer but not quite there.

Voluntary Alternatives to Involuntary Services

- The California Association of Social Rehabilitation Agencies (CASRA) promotes alternatives to hospital settings, in terms of principles and asks that finding voluntary alternatives to involuntary treatment be included in the requirements.
- What is your perspective on people who go into short-term 5150 and then into voluntary programs?
  - **DMH Response (SM):** This is exactly what DMH wants. Hospitals do not want to keep people for a long time. The problem is there is not enough capacity in the system for voluntary programs to release people to. Beds used for administrative days are not useful.
- 5150 usually leads to a conservatorship. We need a system that provides voluntary service.
- Help counties understand how to use strategies to prevent involuntary.
  - **DMH Response (SM):** Outreach and engagement generally needs to include families and consensus working together.
- The job of conservator is to serve the client. It is very painful to tell a family member that this is a fail-first system, – that their family member has to fail before they can get access to the system. To clients, there is a point where they can make the decision to get this support. It is voluntary at all points. There is no point in telling people they have to avail themselves of services offered them. The point is move conservatees to independence. An outreach team could go into the community to make diagnoses and to offer people treatment. If they refuse, the system can keep in touch with them.

Self-Determination

- Members of the California Network of Mental Health Clients read the Network's statement, Response to Draft DMH Three-Year Program and Expenditure Plan Requirements in Sacramento and Los Angeles: The Client Network applauds DMH for hearing the input of the majority of stakeholders at the many workgroup and stakeholder meetings. It believes that a person's involuntary legal status should not affect his/her ability to volunteer for MHSA programs and services, to exercise meaningful informed consent. Despite the fact that a person is under an involuntary status, s/he must exercise choice in entering a MHSA program. They believe it is essential because:
  - Personal recovery is based on choice and self-determination, and the MHSA promotes recovery as a fundamental value.
  - Forcing a person into a program changes the voluntary nature of the program itself for that person, staff and all others in the program.

- MHSA programs, as AB 2034 programs, must be provided on a voluntary basis, in which clients are fully informed and volunteer for all treatment. This does not exempt people under involuntary legal status.
- The MHSA promises a transformation of the mental health system with services that transcend outdated and stigmatizing reactions to people with mental disabilities. Involuntary treatment looks backwards, not forwards. Whereas the conventional system has used coercion and force in its attempt to solve problems, a transformed system would create alternative options that maximize client self-determination and autonomy, goals of MHSA. This does not change for a person under an involuntary hold.
- The Client Network has developed guidelines to support choice for people under conservatorship:
  - An MHSA program will not accept a person unless s/he wants to be there. The conservatee, not the conservator, must make the decision. The conservatee has the right to refuse to participate in an MHSA program.
  - The conservatee should be able to continually consent.
  - There should be an independent person present to assure that the conservatee is making the decision, to protect that person's choice.
  - Entering the program is a way toward getting off the conservatorship.
- The Client Network believes that the concept of consent should be applied to all age groups. The role of children and adults in choosing and directing their services should be maximized.
  - **DMH Response (SM):** This underscores the importance of client engagement. People often cannot give informed consent because they do not know what it is. The role of education of consumers and family members is vital in moving people out of involuntary care. We hope that members of Full Service Partnership teams are active in these discussions.

- One of the guiding principles is that people suffering from mental illness did not choose it. They do not freely decide about suicide, homelessness or jail. The system is not working for many people, especially for those who are also using substances. The system needs to help the family understand what to do. Nobody knows what to do at the onset.
  - **DMH Response (SM):** Unless the system deals with the whole person and does a better job of peer support programs and family education, we will fail. Co-occurring substance abuse is troubling.
- Protection and Advocacy is pleased with the DMH position. These services should be available to anyone. People should have the choice to participate.

Informed Consent

- People say different things about voluntary/involuntary services. Think very seriously about what the implications are, especially for families with conservatorships. Sometimes the conservatee cannot make decisions or an informed choice.
- It is problematic that people say clients are not able to provide informed consent. Psychiatry is the only profession where the client is always wrong. The reason

many people have not consented is because the system is broken. Medication often provides deleterious effects. People do not choose homelessness. People on SSI cannot afford rents. AB 2034 recognizes the need for housing first. Only 5% of people diagnosed with severe mental illness are out on the streets. It is a rare case in which people do not get off the streets. The human rights of people with mental illness do not end where their diagnosis begins. Non-compliance rates for psychiatric medications are the same as for people with diabetes, arthritis, etc. Clients are asking for equity, not just parity.

- With the conservatorship brought up by Client Network, is it up to the conservatee to consent to treatment?
    - **DMH Response (SM):** We cannot make people do what they do not want to do. The court makes those decisions and we can only explain the pros and cons of participation.

Education and Training

- If both partners – conservator, conservatee, mental health provider – are not educated together to understand what it feels like to be on the other side, it will not work. Consumers have to educate everyone about who they are so they can be properly treated. Nobody talks about proper education.
    - **DMH Response (SM):** This is absolutely right. Next month, when the workgroup discusses education and training, this should be included. First, current providers must be trained how to ask the right questions, how to work with families, how to give consumers options. The system will not change until the values permeate the system.
- Place more emphasis on clinical competence.
    - **DMH Response (SM):** MHSA is very interested in this.

Necessary Conditions to Change the System

- Consumers cannot educate themselves in a vacuum. Family members have to be educated at the same time. Consumers want to live with dignity. Consumers can deal with their disability and lead a productive life, helping each other. Consumers deserve dignity and choice.
- DMH's attempt to reform the mental health system in California with limited funding is ultimately destructive because we cannot meet the expectations. Some counties' conservator programs need conservators (for those who are a danger to themselves or others). Back down and turn some control over to parents and consumers and allow county management of what is being achieved on a county level.
    - **DMH Response (SM):** Yes, it is overreaching to think we can transform the system on this little bit of money. But I have faith in people to get many things done. Yes, managing expectations is really hard. I am not going to back down from pushing us to be the best we can be.
- The second draft is encouraging, especially the issue of voluntary, allowing legal status. Los Angeles is planning to set aside money to deal with psychiatric emergencies. AB 2034-type programs can help, but they need augmentation. Los

Angeles is determined to do the type of outreach that works. An enormous amount can be done by doing the right outreach, reaching people who have been resistant. Peer-to-peer outreach is most important.
    - **DMH Response (SM):** We need a full continuum.

Other

- Discrimination by the providers and system has been discussed by a large number of mental health clients. We need to think differently about involuntary services in terms of people of color. There is institutional racism.
    - **DMH Response (SM):** Persons of color are more likely to be in an institution: this is institutional racism. DMH staff cannot change institutional racism or eliminate discrimination. However, this debate makes clear the broader issues that everyone should have equal access: no matter what your status is, you should have access to services.
- 5150 is happening now. Law enforcement in one county is using this quite a bit. Consumers do not deserve to be treated badly by law enforcement. Maybe you do not care about what is happening to us.
    - **DMH Response (SM):** I do care passionately. There are a number of counties that are enlightened and see MHSA as a way to get people out of the jails, hospitals and into the community. There are some mental health professionals who do not see recovery as possible. When implementation is complete, a long way down the road, many things will still need to be taken care of. This is just the ramping-up stage.
- What is meant by "administration" in terms of courts and AB 1421?
    - **DMH Response:** MHSA should not pay for the costs of operating the court, such as salaries for judges and district attorneys. MHSA should not pay for the court overhead. It could fund the services. If counties want to have a mental health court, they can use county dollars for that. If counties want to develop a whole program just for AB 1421, they can use realignment dollars. Conservatees and AB 1421 participants should participate in MHSA programs, however, there should not be MHSA programs solely for them.
- 99.9% of the time, consumers access services on a voluntary basis. There are times when people need involuntary services. If people do not want to be there, they are not going to get what they need to turn their lives around. More clients are needed to be hired. We all need to be working together rather than fighting.
    - **DMH Response:** I could not be prouder to be part of this process. I am convinced we will be able to craft something.

Stakeholder Written Comments

Permit Involuntary Services

- Any involuntary treatment should be "state of the art." This is often the first contact consumers and family members have with mental health services.

- Please clearly state in the CSS Plan Requirements "*funding for services for clients no matter what is their status in which they entered the program, voluntary or involuntary*."
- Change the second draft of the CSS Plan Requirements' statement "voluntary in nature" to "*All persons who meet the eligibility of W&I Code 5600.3(b)(c), regardless of legal status shall be entitled to receive community system of care services*." Neither the proposition nor the underlying codes referenced in the CSS Plan Requirements state that all services must be voluntary. To even suggest so indicates discrimination against the people most needing services. Let counties decide what their priorities are regarding funding proposals for voluntary versus involuntary.
- Do not have a reference to voluntary vs. involuntary services in the guidelines. Then the counties can decide what they need though their stakeholders input. The counties then would need to justify to DMH and the Oversight and Accountability Commission their decision in the grant application. After extensive budget cuts to the county mental health departments, there is a deficit of IMDs for adults, hospital beds and high-level group homes for children in the counties. MHSA funds are needed for these beds so family members can visit and maintain contact with their ill family member. MHSA funds should keep families together even when institutionalization and not their lack of funds separate them.
- NAMI wants the language on involuntary to be stricken. Many consumers are upset about this. If even one person kills her/himself because s/he did not have access to care it is unacceptable. What are the reasons for this decision? The truth is some people need involuntary services to survive. The major part of the act is to provide more and more services.
- Do not discriminate against clients who need involuntary services. Drop "voluntary vs. involuntary." Services are services without stigma attached.
- There must be a continuum or array of options including voluntary and involuntary services. When an involuntary intervention is necessary, it must be integrated with voluntary services. There should be no treatment differences or discriminating practices against persons who need involuntary services to those who desire it. Please keep the involuntary clause in the document as was there in the first Draft CSS Plan Requirements.
- Current statistics show that 50,000 people in California jails and prisons have severe mental illness; many more are serving even more inhumane sentences on the street, prey to even more violence and degradation; and suicide continues to be the only relief some ever find. California must always have equal access for the very ill to involuntary services. Until there is a dramatic transformation of the mental health system resulting in a range of appropriate voluntary services, involuntary services are the only way to prevent people with mental illness from suffering the often tragic consequences of untreated mental illness.
- The road to voluntary treatment often begins with the small step of involuntary treatment! In communities of color, it is virtually impossible to expect a mentally ill African American or Latino male to voluntarily seek treatment. The result is jail, three strikes and prison. A 3-day hold is inadequate to achieve judgment capability when most meds require six weeks to achieve a baseline.

- Leaving out the word involuntary is discriminatory. There are people who will understand this as being more stigma.
- Involuntary services may be needed to intercept repeated episodic exacerbations and possible brain damage from psychosis because of the inability to comply with voluntary services and/or anosognosia (impaired awareness of illness).
- Regarding those unaware of their illness, access to services is denied because people "choose" not to receive it. The system has been hiding behind this preposterous notion of "choice" too long. Mental illness can destroy a person's ability to make appropriate choices for their own care.
- It is very difficult to get a paranoid schizophrenic to volunteer for anything, even when they need treatment. How can they be treated without involuntary options?
- The current language about voluntary services needs to be withdrawn, otherwise DMH will get what it has always gotten: a lot of untreated people, deaths and incarceration. Hospital emergency departments will remain flooded with severely mentally ill people. The system will still be broken. It is a betrayal of those least able to care for themselves.

Do Not Permit Involuntary Services

- Consumers do not need forced treatment and deserve a voice for choice. Thank you, Dr. Mayberg.
- The current draft plan's statement of position on involuntary treatment is good. With regard to people on involuntary status, MHSA programs and services should be available, but only on a voluntary basis, i.e., with the person retaining the right to refuse.
- If an involuntary treatment is tried and tried again and the treatment does not help, continuing the torture is immoral.
- MHSA is not for involuntary programs.
- Involuntary treatment is like a pestilence that is out of control. To end this pestilence, the mental health system needs to become a wellness and recovery-based system.
- Protection and Advocacy supports DMH's revised position prohibiting MHSA funds for involuntary treatment as set forth in its second Draft CSS Plan Requirements. MHSA was designed to transform the mental health system into a choice-based system, not to backfill current involuntary programs. MHSA services can be made available to people on involuntary commitments, but the services themselves must be voluntary. Involuntary services can only be provided under the Lanterman-Petris-Short (LPS) Act, which is clearly available. MHSA does not authorize involuntary services of any kind, not to people on probation or parole, not to children (although the right of parents/guardians to consent on behalf of their children is present) and not for AB 1421 programs. The letter and spirit of MHSA require that we move away from a fail-first system and toward a transformative system based on recovery principles, community-based services, choice and human dignity.
- Respect people's voices and do not force treatment.
- In terms of "voluntary," explain what is meant by legal status. Whatever a person's involuntary legal status, he/he should exercise choice in entering a MHSA program.

- Thank you for stating that services must be voluntary in nature. It supports the recovery vision.
- Add "voluntary" and "strategies to enhance voluntary" to list of Essential Elements.

Clarifications Needed

- Page 2: "Services and programs funded under the MHSA must be voluntary in nature. Individuals accessing these services may have a variety of legal status…." Personal recovery is based on choice and self-determination; the MHSA promotes recovery as a fundamental value. MHSA programs, as AB 34/2034 programs, must be provided on a voluntary basis, in which clients are fully informed and volunteer for all treatment. This does not exempt people under involuntary legal status." Clarify "voluntary in nature," "variety of legal status." Define these terms clearly.
- Dr. Mayberg mentioned that funds would not be used to pay for administration of a mental health court. What does he mean by administration? Does that mean probation officers dedicated to supervise severely mentally ill could be funded through MHSA?
- Please clarify in plain language the definition of "voluntary" in a commitment situation, i.e., inmate in prison, conservatee in a conservatorship. Will DMH approve MHSA monies for a program offered for those people? Does DMH accept that people with mental disabilities in those situations may not choose services offered?
- ACT is involuntary in nature.

Other

- Much of the discussion of voluntary vs. involuntary is meaningless. Many consumers and family members can agree on specific concepts and proposals that may have an involuntary component if the programs are evidence-based, focused on wellness and recovery and compassionate alternatives to incarceration.
- Some consumers function much better on medication than without. If they do not take medication, their symptoms become severe and they refuse medication. Involuntary services should only be permitted if specified by the consumer. Some consumers want to be forced to take their medication if their symptoms are severe. Do not force it unwanted. Do not give up on those who refuse it, please.
- Hiring clients and peers will help stop involuntary services.
- One of the best ideas presented was to use peers to help acutely ill make choices in their best interest. Can this be emphasized?
- The next step is doing away with conservatorships.

F. Update on Mental Health Services Act Oversight and Accountability Commission

David Dodds, Oversight and Accountability Commission Interim Executive Director provided an overview of the progress of the Commission at the Sacramento meeting. Mr. Dodds was hired to oversee start-up of the 16-member Commission.

The Governor's Office expects to announce appointments within two weeks. Mr. Dodds hopes to hold the first meeting within ten days of the announcement of all appointments. This meeting will be an orientation, since many will not have served on a commission before. Commissioners will learn about the State and MHSA regulations and will be encouraged to choose a chair and vice-chair. There will be an Executive Director and six support staff. All these positions are civil service positions which have to be established according to the rules of personnel administration.

Stakeholder Questions and Comments

- Although only two of the sixteen members are required to be consumers, consumers should represent a good majority of the commissioners. This is important.
  - **Oversight and Accountability Commission (OAC) Response (David Dodds (DD)):** This is part of why the Governor's Office is taking so long with the appointments: they are working on balancing all members.
- Our advocacy group has submitted names and we have heard nothing.
  - **OAC Response (DD):** Some of the interviews are still happening. Wait and see what the representation is.