Contra Costa Mental Health Commission
Monthly Meeting
April 8, 2010
Minutes – Approved 5/13/10

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 4:30 pm by Chair Peter Mantas.

Commissioners Present:
Dave Kahler, District IV
Peter Mantas, District III
Colette O'Keeffe, MD, District IV
Floyd Overby, MD, District II
Anne Reed, District II
Teresa Pasquini, District I
Annis Pereyra, District II
Sam Yoshioka, District IV

Commissioners Absent:
Carole McKindley-Alvarez, District I
Supv. Gayle Uilkema, District II

Attendees:
Dr. Michael Cornwall
Brenda Crawford, MHCC
Tom Gilbert, Shelter Inc.
John Gragnani, Local 1
Steven Grolnic-McClure
Ralph Hoffman, NAMI
Jim Kenshalo, CSU
Karen Rulliey
Leslie Rubman

Staff:
Donna Wigand
Suzanne Tavano, MHA
Sherry Bradley, MHA
Dorothy Sansoe, CAO
Cindy Downing, MHA

Introductions were made around the room.

2. PUBLIC COMMENT.

The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant.

3. ANNOUNCEMENTS

A. Report on Value Stream Mapping Event at CCRMC-Vice Chair Pasquini, Commissioners Kahler and O'Keeffe:

Vice Chair Pasquini said the week was a successful and exciting collaboration of community members. She passed around a picture of the team and a copy of the report that came out of the event. Anna Roth has been invited to present at either the May or June MHC meeting.

Commissioner Kahler said big, positive changes are happening at CCRMC. Last week's event was centered on the CSU and the acute care Ward C. A huge change will be the reopening of the CSU door to psychiatric patients so they will no longer enter the CSU through the ER that is set to happen May 17.

Commissioner O'Keeffe said Kaizen events can result in very effective changes such as the recent CCRMC kaizen event for improving the process for heart attack patients coming into the ER. The result is a system change to get patients to the John Muir cardiac cath lab within 30 minutes. She requested the limits of the Kaizen model be appreciated before implementation at CCRMC. She expressed the desire to reflect on what worked and didn't work with Toyota at the NUMI and Van Nuys plants before implementing a similar program here. The inside supports at those two plants was present, but not always the outside supports. For this approach to be successful at CCRMC, outside support systems must be engaged and she doesn't feel they are. What will fix things are housing and appropriate mental health services for outpatient services. She recommended a book, Dirty Rotten Strategies: How We Trick Ourselves and Others into Solving the Wrong Problems Precisely as illustration of what she feels Kaizen is doing. Two things distress her: 1) the principal of "patient added value": deciding what was a good thing in the system by what the patient would be willing to pay for it. She feels what she (having been 5150's twice at CCRMC) and other patients would have paid money for was getting out of CSU as quickly as possible and 2) because of the time and motion study, the downtime was seen as lost time where as downtime is necessary when someone is going through a mental health crisis. Downtime allows a patient to regroup himself/herself; a patient needs time to be left alone and it is difficult when people are "invading your space". A 5150 experience can be very frightening and time and motion studies do not address that. Commissioner O'Keeffe could not morally or ethically continue with the process (and did not participate for the entire week); there were 11 people with clipboards, each following a patient, standing behind the nurses in CSU. She was outraged and felt it was inappropriate to have all those people watching and writing down information about the patients during a time of crisis. That is part of solving precisely the wrong problem. Kaizen can help with certain functions, such as getting lab work done in a timely manner, but she is unsure of the values that allowed what took place at the Kaizen event at CSU last week to take place. She also feels it may have been illegal.

Vice Chair Pasquini expressed her respect for Commissioner O'Keeffe's feelings and perceptions, but strongly disagrees. There were 3 Patients Rights Advocates (from MHCC) on the team and the each of them felt it was a very empowering experience. Brenda Crawford, MHCC Executive Director, told Vice Chair Pasquini each had a "sparkle in their eye" after the Kaizen event. From a parent's perspective, her son has been 5150'd approx. 40 times and was 5150'd 2 days before the Kaizen event began, she thought it was a complete collaboration. It is not about being fast, but about quality care.

Commissioner O'Keeffe said she does not see the quality of care meshing with the Kaizen process. She has spoken with some people privately, when they do not have fear of repercussions from above, who have the same concerns. Vice Chair Pasquini said they can speak to her too.

Commissioner Yoshioka is concerned about the legality of patient consent. Isn't consent required from a patient before observing the process with a stopwatch? Couldn't cameras be utilized to obtain the same information without watching the patient? Aren't we more concerned today about patients' rights and privacy?

Ralph Hoffman stated the 5150 code requires someone be a threat to yourself or someone else. This type of 5150 is based on stigma and should be investigated. His 5150 experience is being investigated. He understands Commissioner O'Keeffe's anger at the situation.

Chair Mantas said he may have felt the same way Commissioner O'Keeffe did about having someone walking around with a stopwatch, but the end result of the process is a great deal of invaluable information resulting in positive changes. Commissioner O'Keeffe's experience should be communicated back to Anna Roth. In the past there were things family members experienced in the CSU that were dismissed, but these were confirmed during the Kaizen event.

Commissioner O'Keeffe said Chair Mantas is basically stating "the end justifies the means". Just because some good comes out of something, doesn't excuse the bad that occurred to produce it. There is something worrisome about a process that would have this as an initial event. What went wrong with a supposedly effective process to produce outrage such as this? There is not time today to analyze the NUMI process and the difficulties in transplanting it from one culture to another. If we are not willing to look at the problems within the system, we will continue to run into problems and hope for good outcomes through things that shouldn't have been allowed to happen in the first place

Chair Mantas said he didn't mean to imply the end justifies the means. The Lean process has been very successfully applied to other hospitals and he hopes CCRMC has done its homework on the legality. The MHC will pass along her concerns to Anna Roth and see how she responds back.

Commissioner O'Keeffe said she attempted to make her feelings known during the process and was brushed off.

Chair Mantas said the MHC would follow up with Anna Roth through the minutes.

B. Raising the Roof – April 12, 2010 6:00 – 8:15 pm, BOS Chambers:
Sherry Bradley said this is another example a stakeholder-driven process. Members of CPAW with an interest in housing, including Commissioner Pereyra, have worked together to put together a panel of experts to assist mental health consumers and their families in CCC learn about housing options. Information about met and unmet housing needs as well as the steps to develop housing. It will be taped by CCTV and dvd's will be made available for use as training tools.

4. **APPROVAL OF THE MINUTES**

- **ACTION: March 11, 2010 MHC Monthly Meeting – Motion made to approve the minutes. (M-Kahler/S-Overby/Passed, 6-0, Y-Pasquini, Mantas, O'Keeffe, Kahler, Overby, Pereyra/ A-Reed and Yoshioka)**

- **ACTION: March 11, 2010 MHC Innovation Public Hearing – Motion made to approve the minutes. (M-Kahler/S-Pereyra/Passed, 6-0, Y-Pasquini, Mantas, O'Keeffe, Kahler, Overby, Pereyra/ A-Reed and Yoshioka)**

- **ACTION: March 11, 2010 MHC Technologies Project Proposal – Motion made to approve the minutes. (M-Overby/S-Pasquini/Passed, 6-0, Y-Pasquini, Mantas, O'Keeffe, Kahler, Overby, Pereyra/A- Reed and Yoshioka)**

5. **REPORT: MENTAL HEALTH DIRECTOR – Donna Wigand**

She shared Michael Oprendek, the Solano County Mental Health Director died unexpectedly yesterday. He dedicated his entire career to public mental health and will be missed.

The CCC budget document will be released tomorrow. She cannot share details until it is made public, but the Mental Health Division reduction is approximately $1.5 million, the 9th reduction in the last 8 years. There have already been some reductions in psychiatric and clerical time that will be credited toward the reduction, but there will not be any line staff layoffs or closing of clinics or programs at this time. Some vacant administrative positions will go unfilled. Vice Chair Pasquini asked which positions, but Donna Wigand did not know off the top of her head. April 20, 2010 at the BOS is the budget hearing for the entire County.

Vice Chair Pasquini asked what a loss of psychiatric time meant. Donna Wigand said in the last 9 months, close to 85 hours of psychiatrist time were allocated to Ambulatory Care. Last year Dr. Walker began an initiative integrating psychiatry more closely into ambulatory care and having some ambulatory care services provided in the mental health clinics. They are working on developing an ambulatory care clinic within the Concord Mental Health Clinic. Some psychiatrist time was loaned to Ambulatory Care they thought would be backfilled, but with this reduction, it will not.

Commissioner O'Keeffe asked what affect that would have on waiting times to get appointment and Donna Wigand said the 85 hours have been gone since last year so the effects are already being felt.

Commissioner Pereyra asked where the 85 hours came from. Donna Wigand said it is over 2 full time people.

6. **CHAIRPERSON'S COMMENTS – Peter Mantas**

Chair Mantas introduced Vice Chair Pasquini to share a troubling personal experience. He felt that this experience would be helpful to helping Commissioners get exposure to some critical issues. Vice Chair Pasquini read a statement on an experience she had on 4/7/10: "This is how I spent my afternoon yesterday….a consumer phoned me and was threatening to commit suicide. I kept her on the phone, trying to calm her down while I emailed Gloria Hill, Vic Montoya and her case manager in West County and nobody responded. So I was able to calm the consumer and explain that I was going to call a friend. I grabbed my cell phone and called Gloria Hill who apparently then handed the phone to Suzanne Tavano (Gloria was unavailable). Suzanne proceeded to tell me/ask me to have her go to CCRMC. I tried to explain and said "Suzanne, she is in Richmond, alone in her apartment with a knife in her room, I am trying to get someone to call 911 while I keep her talking to me on the phone." Suzanne finally understood (there were some cell phone connection issues) and at some point the consumer finally hung up. Suzanne was able to call the Richmond Police. I got a call from them. I'd also in the meantime emailed Rubicon and got a response from Steve who informed me he and the therapist were going to immediately go to the house.

I got a call back from Steven saying that they decided she was ok and because she contracted not to kill herself, they left her. The Executive Director told me, "To be honest, she will probably go out and get wasted tonight. I hope she won't do anything to herself, but we have done everything that we can do."

When I asked about her medication and that she reported that she had none. He said, "Oh, she is really excited about starting an injectible next week." She saw the doctor yesterday and they discussed it. There are additional parts of the story I'm not going to share publicly, but I hung up hopeless and thought to myself, "what about this week? What about today? What about the day she saw her doctor? Why didn't it start that day?"

So, even with the Mental Health Commissioner of West County's advocacy and support, and shouting from the roof tops for intervention, attending case conferences where there is defensive posturing, and sending emails to all top MHA administrators (most of whom are in this room), this consumer has been left to her own demons in an unsafe area of Richmond where she can fail over and over, make poor choices and get beaten every other day until a day like yesterday when she said, "I can't do this anymore."

This was another sign of many I have been given to speak truth to power today and not play any political games today and I will continue to speak truth to power.

Two of the Executive Directors of contract agencies who have contracted with CCC's MHSA CSS plan to provide programs for the Adult Full Service Partners have publically stated that MHA provided no support for them to implement these programs. They have also publicly reported that MHA renewed their programs without even MEETING with them to discuss if they were actually working…the big picture has been forgotten by Local 1, Mental Health Management and some CBO's, but not by me.."

Suzanne Tavano said when she spoke to the Police they assured her they were on their way and she made a call to Dr. Thomas at the CSU who was prepared to accept her and then she didn't get a call back from anyone so she assumed it had resolved.

Steve Grolnic-McClure said although he couldn't talk about the specific case, but there were a number of inaccuracies and he was very involved in what happened last night. If somebody is not suicidal, and states they are not suicidal, and contracts they are not suicidal and expresses no interest in having any level of care, then they are not going to be hospitalized, as they shouldn't be. It's someone's choice. That was the situation. It's wonderful the support was there and he appreciated Commissioner Pasquini reaching out and making sure she got care last night. He's concerned this person's story is being made public without her desire for it to be made public and he's concerned how it may affect her care. He's concerned about some of the statements made and concerned about some of the inaccuracies stated. He would hate for anyone to feel that there was not proper care for some who is struggling very hard.

Chair Mantas asked if Steve Grolnic-McClure could talk about the inaccuracies he heard. Steve Grolnic-McClure said if he gets too much into the details, he would be violating their privacy and he can't do that. He can understand why somebody on the other side can have a different perspective on what happened. If there had ever been a judgment by a clinician, and there were several licensed clinicians working with this person, that somebody was not safe, by the definitions of what's safe, that person would never be left alone. If there were a question, the police would be called and could make their own evaluation of the situation. In general, the statement about the living situation of that person was somewhat inaccurate.

Commissioner Reed asked if someone is not 5150'd but reports had been heard about an individual, who prior to that has contracted not to kill himself, saying I'm going to kill myself, are there standard operating procedures for follow-up the next day or the next couple days? Steve Grolnic-McClure said yes. In this case, if someone was able to put in writing he/she would not hurt themselves and the several steps they would take should they begin to have those feelings of wanting to hurt themselves, that would indicate they are not planning to do that. They would make sure the (phone) numbers they should reach out to are in very clear places and go over with the person what they should do if they begin to feel that day. The person would be contacted immediately the next day. As with all MHSA programs, there is a 24 hour crisis line, that can be called during the night. In a situation like this the crisis line would be alerted of the situation. That would be standard operating procedure.

Commissioner O'Keeffe said it is unfortunate that a person must meet the strict reading of the 5150 code before being hospitalized because sometimes a person in distress/turmoil (and almost meeting the criteria) would be greatly helped with a 2-3 day hospitalization rather than deteriorating further and requiring a 2 week hospitalization. It would save the County money as well as being more humane. This reflects the pressing need for a running Crisis Residential Facility.

Brenda Crawford is aware of the some of the concerns people have about the relationships between groups in the collaborative. She would like to go on record as stating those relationships or lack of relationships have never impacted delivery of services.

Mariana Moore (on behalf of the Alliance) expressed her discomfort about the way the contracting process is being discussed and feels it may be inappropriate. She requests the MHC create for itself and members of the community who engage with the MHC clearer guidelines around what's appropriate and what's not appropriate when discussing contracting issues. There are some contracting issues between the County administration and its contractors and there may be broader lessons, themes or trends that are appropriate to talk about in a public setting. She doesn't think it is appropriate to be discussing a specific case as it breaks protocols and possibly confidentiality. She requests the MHC have a more thoughtful, intentional protocol.

Vice Chair Pasquini responded she is authorized to speak on this consumer's behalf. She appreciates Mariana's opinions, but she feels she is fighting for this consumer's life. If she is breaking any little technicality….and she disagrees with Steven's characterization of inaccuracies. She would like to turn this over for the record and after their conversation this morning, she is aware of their disagreement on the topic. Her comments about the contractors were made in full hearing of CPAW several times. She doesn't think she is saying anything tonight that hasn't already been said in other forums.

Chair Mantas said the reason he wanted Vice Chair Pasquini to speak on this issue does not have anything to do with contracts. This is a situation that happens, hopefully not every day. She was on the phone with the consumer, unable to call 911, and emailing for assistance. The calls were made to 911 and they responded in a timely manner. This individual called her for a reason. Something more should be done than asking a few simple questions, saying "you're fine" and leaving her alone. It may the thing to do, but there should be more. It's an opportunity for everyone to know what actually goes on. Vice Chair Pasquini advocates not only for her son and

this consumer, but others who reach out to her and she wants to educate us on her findings. He thinks it is appropriate for this venue.

Steve Grolnic-McClure said the number and types of services this individual, and any other individual at that level of distress, received is extremely large. To portray is as "this is all that they got" is very inaccurate. There is a crisis line anyone can call, the County reached out as soon as they heard and there was a very quick response by all parties. Teresa was in a very difficult situation and it is a situation many providers deal with on a daily basis and bring with them all their training and experience.

Chair Mantas said this discussion is a "snapshot in time" and additional things should be considered to help individuals in distress. Hopefully it will open up a dialog on what more we can do.

A. Update on line staff's assessment of Mental Health Division Administrators
Chair Mantas met with Donna Wigand and Suzanne Tavano several days ago and was advised they are in meeting with representatives from Local 1 are are discussing numerous issues from the assessment. He requested a list of discussion points be provided to the MHC and Local 1 has decided not to formally present that citing it is part of their collective bargaining agreement on labor issues. He will let John Gragnani present Local 1's position.

John Gragnani said although Rollie Katz did not want to provide a list, for reasons specific to him, they agreed to presenting general topics under discussion with MHA including: IT needs and support, community's involvement, productivity policy, training/staff development issues, organizational/structural issues and treatment issues.

Donna Wigand agreed it was a good summation and they have met 3 or 4 times with 2 more scheduled this month. Local 1 brought a list of concerns to MHA that was turned into a workplan of goals and objectives and timeframes. Each item is being addressed and she feels most things on the list are doable. MHA has been going out to the regions (West, Central and East) and invited all staff (both Children's and Adult Local 1 staff, clerical, nurses, consumer staff and family staff) to share their concerns directly. The first meeting was last week in West County and it went well.

Chair Mantas read from an email from Rollie Katz: "In short, the process(es) in which we are now engaged with management are within the realm of collective bargaining/labor relations-discussions/proposals/counter proposals/personnel issues, etc. conducted between the parties." That's why he has taken the position not to share the information with the Commission at this time. It is their prerogative not to share the information, but since it was made public and brought to the Commission he wishes the MHC were receiving more updates on what is going on.

Suzanne Tavano said she has visited almost all the county run programs and reviewed the organizational structure of the MH Division, the history and evolution of mental health in California and "Mental Health Funding 101" including how all the issues tie together. She wishes she had done that 1-1/2 – 2 years ago. Staff has been receptive and welcoming at all the meetings and they are working incredibly hard.

Public Comment read by Dr. Michael Cornwall: until he retired as a full time line staff therapist 3 years ago, he was a member of Local 1 for 28 years, first as a mental health unit shop steward, then a chief shop steward, vice president then president for 8 consecutive 2 year terms. 2 days ago, his successor, John Gragnani, Unit President, phoned him and they spoke exclusively about how he and Rollie Katz have handled the management performance survey that exposed areas of failed leadership on the part of Mental Health Administration. He told John he felt he and Rollie had betrayed the 132 members who completed the survey. The survey revealed a severely demoralized staff who had been neglected and mistreated by management. Instead of informing those staff of the hostile response to the survey by Dr. Walker, Donna Wigand and Dr. Tavano, warning the staff the top administrators said the survey constituted "character assassination" and was "slanderous and must be removed from public view at once", Rollie and John have systematically kept those hostile responses to the survey secret. They have withheld that game changing information from the 132 staff who completed their survey and who deserve a full accounting from Rollie and John about what management said about the survey when they met with management. He told John he felt if the staff known how their survey was angrily scorned and dismissed, the staff would have demanded Rollie and John stop meeting with management and go public with the survey to the (CC) Times and BOS. These line staffs are all professional line staff who know that any relationship requires a working partner who is capable of taking to heart the needs and wounds of the other. For management, from Dr. Walker on down, to so condemn and dismiss their survey meant it was time to get help from those outside the Health Services Department, to go before the court of public opinion and to the BOS to receive a fair hearing of their grievances. He also told John none of the listed items of extra contractual deliverables he heard about has been extracted, in his opinion, by Local 1 from Donna as she desperately tries to keep her job, addresses Donna's, Dr. Tavano and Vern Wallace's specific failing grades on several of the survey questions that are exclusively about damage inflicted by those managers on their relationship with line staff. John said it would have hard to address those more subjective complaints of line staff that emerged in the survey. And this is from a licensed therapist who every day searches for ways for the subjective, emotional needs of all family members to be heard, valued and addressed so that everyone in significant relationship feels safe and respected. Amazingly, neither he or Rollie never simply asked the following three questions so obviously begged by the survey: 1) Donna, the survey claims you and your top staff have neglected and mistreated line staff. Do you agree? If not, why not? If so, what are you all going to do to heal your damaged relationships with staff? He also told his old friend John he loved him and would take a slug for him, but what he and Rollie were doing was not right. I feel the same way towards his other old friend in this crisis, Donna Wigand. Commissioners, if those subjective feelings of line staff, who have been neglected and mistreated and not given the light of day in resolve, then no amount of papering over this elephant in the living room with unrelated deliverables will resolve the morale issues that diminish each staff's abilities to serve consumers face to face every day. Please take his remarks into account as you proceed in doing your mandated duty to help make the mental health system the best it can be.

John Gragnani said he respects Mike Cornwall as well and appreciates him as a personal mentor and his commitment to the CC Mental Health system as chair of the Mental Health Commission. He'd like to make clear the process Local 1 is engaged in with MHA is a short term process and he fully expects some short term improvements made, but there are long term goals issues and challenges that have been clearly identified in the evaluation. Those same questions and challenges will persist long after this internal process is conducted and completed. He has been up front about that from the start; it's not just about short term deliverables. This was an

evaluation and assessment that identified issues that should be and will be addressed in the short term as well as some long term issues that will persist.

Commissioner Yoshioka appreciates Dr. Cornwall's concerns, but he feels Local 1 and MHA are going in the right direction by talking to each other. If something can't be resolved between two people, take a friend and try again. Some of the things that have gone on are contentious and distracting; issues need to be resolved by going directly to the person.

Chair Mantas said that is the approach he has taken in this process. He's been told many times that he is being negative. However he insists that he was just voicing constructive criticism for the process and communicating the problems he's been hearing. There are no answers after months of attempts to get resolution or a plan for resolution.

Vice Chair Pasquini said she appreciates the efforts of MHA and Local 1 team; it's always good to talk. From a Commission perspective, she feels the Commission is the union for the public and one of our jobs is to protect the taxpayers who pay the salaries of both line staff and management. The MHC is the union for the consumers and families who have been devastated by failed leadership of this administration. If there is not some form of mediation that includes the Commission, she can't support the process taking place. She rejects that this is a collective bargaining issue and bringing it to the Commission makes it part of their agenda. There have been discussion of Commissioners having their own agenda, but their agenda is publicly noticed and discussion is taking place in this room. There have been too many backroom discussions that have not included the public. She views the survey as a failing grade in management of the mental health system. She would like directly ask how the MH Director and Deputy Director feel about the survey? She hadn't asked directly.

Donna Wigand said of course she felt terrible, but she wasn't going to go into a diatribe on it. She feels she and her managers, who were slammed, are genuinely reaching out and trying to have a better relationship. She asks that people give that process a chance. She feels there are people in the room who do not wish that process to succeed; she does. She wants her staff to feel good about coming in to work in the morning. She knows how hard the jobs are. She wants her staff to have the best morale possible at this time and she's working on it.

Suzanne Tavano said there was a written response to the survey; everyone had it. She felt everyone was very hurt as they felt they had good relationships with staff; it was a little surprising to see it. There was a response to the structure of the survey itself, not discounting what people said or their feelings, the statistical analysis of the survey. Some staff who didn't work in the Mental Health Division were included and some staff who did work in the Mental Health Division were not included. They responded on a technical basis to the survey but not to the feelings of staff. She felt she had to put those personal feelings aside because the most important thing is a productive, positive relationship between administration and staff as that ensures access and appropriate services to the consumers. Although the survey was hurtful, she doesn't carry bad feelings towards the staff. There are a lot of wonderful staff who are working incredibly hard; she's not going to let the survey get in the way of building relationships. She would like to focus on what they can do moving forward to make things work better.

Commissioner O'Keeffe asked if line staff felt demoralized and left out regarding how decisions were made, how are they being kept in the loop now and how they are feeling about how things are proceeding? What is the plan to keep them feeling included?

John Gragnani answered regarding the survey approach process was step by step. Each timeframe and goal involved the members, including the possibility of another survey in the future. Regarding the membership being involved, he feels members are informed.

Commissioner Reed said whether the members are being informed is a union issue not a MHC issue. We need to remain focused on our mandate, moving forward on action items we can act on.

John Gragnani said he has always wanted to be open with the MHC and it was always the plan to have a public release of the plan. He appreciates the concerns around backroom deals.

Chair Mantas said he has been put in the unfortunate position of hearing of what's going on in the background and there are significant anomalies compared to what he is hearing today and it's why he wanted to bring this issue up. He is concerned about what administration is continuing so say about him … That he is being negative and he is hoping the process will fail. He would like the mental health system to be as good as it can be given the financial conditions we are in. When he gets information, he has to act on it and not just hope it goes away; he hears things from many sources. There are issues between the union and administration that need to be discussed; we need to get to the bottom of the issues. The Commission will speak, but this is his opinion.

Dr. Michael Cornwell said he appreciates people talking right now. Suzanne Tavano, Donna Wigand and everyone has feelings. If there are core issues, why are they being delayed? He asked John Gragnani why not put them up front? Maybe there needs to be a mediator; he recommended at the February MHC meeting "reconciliation" needs to happen between management and line staff. The real issues are not being addressed. He is not here to see anyone in management leave; he would like them to work it out. Something happened. Last year when he received a call from John Gragnani requesting a meeting with him and Debra saying they were being attached by administration. Staff was being told they might lose a week's pay or possibly their job, John suggested a vote of no confidence for the Donna Wigand or a management performance evaluation, he said have a management performance evaluation. He requests they work things out, but if they are unable to, don't pretend it has been worked out.

Chair Mantas hopes in less than a month, the MHC will be updated on solutions to the issues that keep coming up. He's not comfortable with what's been going on and if progress isn't shown he is prepared to additional procedural steps. The MHC is hearing things from both administration and the union. The problems need to be fixed so the community everyone is to serve is taken care of.

B. Regular monthly meeting location: Recommend that we hold our regular monthly meetings at 651 Pine Street Martinez, Room 101

Chair Mantas removed this item from the agenda, but he will be seeking a location with better public transportation access.

Commissioner O'Keeffe said she spoke with Supv. Bonilla's office and there are other options closer to transportation hubs.
To Do: Staff to follow up on other location options.

Commissioner Reed requested any location we have must have unlocked doors and be handicapped accessible during the course of the meeting. Chair Mantas asked if this location did not meet the requirements. Dorothy Sansoe said the doors to the building are locked at 5:00 – 5:15 pm unless arrangements are made with General Services who will charge for a custodian to come back and lock the doors. Chair Mantas was unaware this location was out of compliance.

Ralph Hoffman said having meetings past 6:00 or 6:30 pm may be a violation of the Americans with Disabilities Act in that there is no public transportation available in Martinez past that time.

C. Appoint Taskforce to research and propose MHSA plan process changes. This will include MHC involvement prior to the development and posting of plan for review. Also recommend CPAW member makeup and member voting rights.

Chair Mantas said the current process for review of MHSA plans is not working. It was evident at the public hearings earlier in the week. The MHC comes into the process too late to provide any significant input to the process and the MHC is told they have to approve a plan or the County and consumers will lose funds. After months of attempts to effect a change, nothing has happened. He would like to appoint a task force to research and propose MHSA plan process changes to include MHC involvement prior to development and posting of a plan for review. The task force will also recommend CPAW member make up and voting. In addition to the Commissioners involved in the task force, individuals from MHA and members of the public would help in the process.

Sherry Bradley would like to address the second part of the agenda item: the composition of CPAW and voting rights. In additional to existing law regarding mental health commissions and mental health boards, the law already provides for the composition of local mental health boards, it also provides direction under MHSA regulations regarding the important role stakeholders play in the overall movement of the mental health system towards transformation. The stakeholder processes are fundamental to achieving transformation that drives MHSA plans. Before taking any action, she wanted to remind the The W&I Code, section 5848a. *(handout follows the minutes)*, on page 9, defines stakeholders, from MHSA regulations: Each plan and update shall be developed with local stakeholders, including adults and seniors with serious mental illness, families of children, adults and seniors with serious mental illness, providers of services, law enforcement agencies, education, social service agencies and other important interests. In Title 9 regulations, stakeholders are defined even more specifically: stakeholders mean individuals or entities with an interest in mental health services in the state of California, including but not limited to individuals with serious mental illness and/or serious mental disturbance and/or their families are required to do mental health services planning. Also the total number of consumers currently participating in CPAW are 10 and 8 family members. Of the 26 current participants, more than 30% are consumers and/or family members. This process is complicated and she encourages the MHC not to recommend the composition and/or voting rights of an integrated stakeholder workgroup which is put together at the direction of the MH Director to comply with regulations they already have to comply with. It would be counterproductive to do that; we need to have more stakeholders, not fewer. The proposed composition, similar to the MHC

composition, was included in the referral letter to the IO Committee. The MHC composition is laid out in the statutes; CPAW's composition is laid out differently.

From the public hearing she highlighted Prevention & Early Intervention and Innovation, there seemed to be a lot of questions about what can be done with those types of funds.

Chair Mantas agreed it is complicated and we should have more not fewer stakeholders. Hopefully the IO Committee will provide suggestions to the Mental Health Director, Sherry Bradley and the Board of Supervisors on their thoughts. He asked who was interested in participating on the task force. Commissioners Kahler, Overby and Pereyra and Chair Mantas volunteered. He asked if Sherry Bradley would participate. They will ask others as well. He hopes to come up with suggestions that will meet the W&I Code.

7. **MHC COMMITTEE / WORKGROUP REPORTS**

A. MHC Capital Facilities and Projects/IT Workgroup –Annis Pereyra

She is planning on holding a meeting soon, but needed something clarified prior to that meeting. She asked Donna Wigand for clarification on her comments that it did not matter how much of the $10.2 million Cap Fac/IT funds was allocated to IT because the capital facilities portion was going to get built. Then in documents and at the Family and Human Services meeting, it was said that because $6 million had been allocated to IT, the Crisis Residential Facility (CRF) was not approved at 20 Allen. When the FHS held their meeting, only the Assessment Recovery Center (ARC) portion was being put forth to the BOS. The CRF was awaiting approval by them and it has not been determined if the CRF will go into the 20 Allen project.

Donna Wigand said no program has been approved yet. Only the purchase of the property and the use of the property for mental health services has been approved. Health Services Finance's (HSF) program thoughts were to roll out programs one at a time rather than simultaneously and a policy decision had been made to go with the ARC first. It may not be set in stone; that is HSF's decision. She is not "married" to any one program. Her biggest concern is to get something that is mental health related on the property before it is used for something else. She was sorry she couldn't stay at the public hearing, but she understands there was a lot of discussion about the CRF facility and the MHC as whole was leaning more towards advocating for that program.

Chair Mantas clarified the motion passed recommended to the BOS both the ARC and CRF be proposed at the same time rather than doing one over the other. It passed unanimously.

B. Quality of Care Workgroup – Peter Mantas

Commissioner McKindly-Alvarez, Chair of the Workgroup, submitted a report with the recommendations formulated at their last meeting. Commissioners Pasquini and Pereyra clarified Community Partners preferred the term "multi-tiered system" since they felt the"two tiered" excluded certain groups. The Commissioners did not have any questions.

- **<u>ACTION:</u> Motion made to adopt the proposed workgroup goals, including the referral of housing and site visits to the Capital Facilites Workgroup (M-Overby/S-Pasquini/Passed, 8-0, Y-Pasquini, Mantas, O'Keeffe, Kahler, Overby, Pereyra, Reed, Yoshioka)**

Discussion:

Sherry Bradley clarified for the MHC Capital Facilities Workgroup the definition of "capital facilities" includes housing. Chair Mantas confirmed yes.

C. Diversity and Recruitment Workgroup – Anne Reed

Commissioner Reed reviewed the approved Workgroup mission statement and the focus areas given to them for their action plan. In February, she, Mariana Moore, Brenda Crawford and Sam Yoshioka met to take the outline developed last summer and begin to craft an action plan. Recommendations are premature at this time because there are several ongoing action items designed to continue to gather substantive information to be used as the basis for recommendations. These action items include reaching out to other county MHC's to see how they address the diversity issue, creating a list of underrepresented communities and pre-exisiting organizations serving those communities and determining what resources are available to other county commissions and committees dealing with accommodations for people who may not be able to fully participate due to disabilities.
They selected 4 main areas: recruitment, selection, on boarding and retention. After getting more information, they will make recommendations. She would like to defer action for a future meeting. *(handout follows minutes)*

Chair Mantas challenged the Workgroup to come up with a plan to reach out to community members to identify people who are interested in helping the MHC become fully staffed, with special attention paid to the diversity of new members, as a top priority. Commissioner Reed felt more than one priority can be addressed at the same time and noted that the marketing of the MHC was already on the priority list. If the MHC doesn't market itself, no one will know we are there. Chair Mantas offered his help.

Vice Chair Pasquini encouraged contacting Supervisor's staff to educate them on the application process and the balance of the Commission. The Consumer position has been vacant for 2 years in her district. There was also a comment from Supervisor Glover he was concerned the MCH may not have liked or approved of his selections; she was not completely clear on the comment. This Workgroup was created last year based on comments about a lack of diversity on the MHC and she believes the Supervisors are interested as well. Commissioner Reed clarified partnering with the Supervisors' offices was included on the second page of the handout, which was not copied in error.

Commissioner Reed stated the diversity has to be a commitment by all the MHC Commissioners, not just those on the Workgroup.

D. Bylaws Workgroup Update – Peter Mantas

The Bylaws Workgroup has met and the recommendations will be presented in May.

8. **REPORTS: ANCILLARY BOARDS/COMMISSIONS**

A. Mental Health Coalition – None

B. Human Services Alliance – Mariana Moore

She thanked Donna Wigand for her fight to retain direct services during budget reductions.

Chair Mantas asked if there was anything we could do collectively to present strong point to the BOS at the budget hearing, please share those talking points, specifically on saving funding and keeping services.

Mariana Moore said a powerful way to have our voice be heard is for the MHC to advocate at the state level when the budget is released this summer.
Suzanne Tavano said when the state budget is released, an analysis is prepared and that can be forwarded to everyone. Chair Mantas said it would be helpful to look at it from County perspective as well.

C. Local 1 – None

D. Mental Health Consumer Concerns (MHCC) - Brenda J. Crawford

She reported the effect of the Kaizen event on the Patients Rights Advocates from MHCC staff was very positive. They felt they were part of a change process that would increase services to consumers. She expressed her appreciation that a record number of Consumers were able to attend the California Association of Rehabilitation Agencies Annual Conference due to increased support for the Mental Health Division. Consumer agencies get together to discuss training and others issues that concern mental health consumers.

Dave Kahler is their crew chief and the Contra Costa Network of Mental Health Clients will be painting the entrance to the CSU using consumer art making it warm and welcoming.

E. National Alliance on Mental Illness (NAMI) – None

F. MHSA CPAW – None

One of the suggestions for the May meeting is to have Rose King, one of the authors of the MHSA, attend or having Anna Roth present how things are progressing with the CSU Lean project.

Commissioner Reed asked what happened to the idea of having someone come in to discuss the internal investigative process that occurs when failures happen. If something is on our plate, we should deal with it and it has not become an agenda item. That item should be pushed up on the list. Chair Mantas said the Quality of Care Workgroup will be looking at the issue and presenting recommendations. Chair Mantas said it should be shifted to item 1 on the Future Agenda Items list.

Vice Chair Pasquini said it was not a Kaizen event last week, but rather a Value Steam Mapping Event. A Kaizen event will be happening the week of the May MHC meeting so Anna Roth may not be able to participate.

Donna Wigand asked if Rose King and Anna Roth are not available to attend the May meeting, would the MHC like David Cassell attend? Chair Mantas said yes since Commissioners seem interested in hearing the information. If this level of detail were being discussed at the Workgroup, the meeting would be agendized so the entire MHC could attend and hear the information.

Commissioner Overby relayed a recent incident with his son at CSU in Martinez being discharged at 12:30 am without transportation home or notifying his family what was going on. Commissioner O'Keeffe thought that a system of taxi vouchers had been agreed upon, but maybe it had been broken down.

9. **FUTURE AGENDA ITEMS**

Any Commissioner or member of the public may suggest items to be placed on future agendas.

A. Suggestions for May Agenda ***[CONSENT]***

1. Rose King (MHSA… The Law) or Anna Roth (CEO CCRMC – Update)

B. List of Future Agenda Items:
   1. Behavioral Court Presentation
   2. Case Study
   3. Discussion of County Mental Health Performance Contract & Service Provider Contract Review.
   4. Presentation from The Clubhouse
   5. Discuss MHC Fact Book
   6. Review Meetings with Appointing Supervisor
   7. Creative ways of utilizing MHSA funds
   8. TAY and Adult's Workgroup
   9. Conservatorship Issue
   10. Presentation from Victor Montoya, Adult/Older Adult Program Chief
   11. Presentation from Crestwood Pleasant Hill
   12. Presentation from Health Services Department on the policies and procedures surrounding sentinel events using Vic Montoya's suggestions on the different reporting structures – David Cassell
   13. Presentation on Healthcare Partnership and CCRMC Psych Leadership
   14. Presentation on non-traditional mental health services under the current PEI MHSA programs

10. **ADJOURN MEETING**
   - **ACTION: Motion made to adjourn the meeting at 6:30 (M-Overby/S-Pereyra/Passed, 8-0, Y-Pasquini, Mantas, O'Keeffe, Kahler, Overby, Pereyra, Reed, Yoshioka)**

The next scheduled meeting will be Thursday, May. 13, 2010 from 4:30- 6:30 pm at the Concord Police Department

Respectfully submitted,

Nancy Schott
Executive Assistant

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours

Meeting Handouts

The following documents were presented at the 4/8/10 MHC monthly meeting (but not included in the agenda packet)

For all other materials reviewed and discussed at the 4/8/10 meeting, please see the agenda packet on the MHC Meeting Agendas and Minutes webpage at

http://www.cchealth.org/groups/mental_health_com/agendas_minutes.php

MENTAL HEALTH SERVICES ACT

SECTION 1. Title

This Act shall be known and may be cited as the "Mental Health Services Act."

SECTION 2. Findings and Declarations

The People of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

SECTION 3. Purpose and Intent.

The People of the State of California hereby declare their purpose and intent in enacting this Act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

SECTION 4. Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

5840.2 (a) The department shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

SECTION 5. Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read:

Article 11. Services for Children with Severe Mental Illness.

5878.1 (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this Part. It is the intent of this Act that services provided under this Chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

(b) Nothing in this Act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3.

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to MediCal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this Part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 of Part 6 of Division 9 (commencing with Section 18250).

(c) The Department of Mental Health shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SECTION 6. Section 18257 is added to the Welfare and Institutions Code to read as follows:

18257. (a) The Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

(b) Funds from the Mental Health Services Fund shall be made available to the Department of Social Services for technical assistance to counties in establishing and administering projects. Funding shall include reasonable and necessary administrative costs in establishing and administering a project pursuant to this chapter and shall be sufficient to create an incentive for all counties to seek to establish programs pursuant to this chapter.

SECTION 7. Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the Department of Mental Health shall distribute funds for the provision of services under Sections 5801, 5802 and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in Welfare and Institutions Code Section 5600.3(b) and (c). For purposes of this act, seniors means older adult persons identified in Part 3.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this Part with the medically necessary mental health services, medications and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in Section 5600.3(b) and (c).

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
  (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
  (2) To promote consumer-operated services as a way to support recovery.
  (3) To reflect the cultural, ethnic and racial diversity of mental health consumers.
  (4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

SECTION 8. Part 3.1 is hereby added to Division 5 of the Welfare and Institutions Code commencing with Section 5820 to read:

PART 3.1 EDUCATION AND TRAINING PROGRAM

5820. (a) It is the intent of this Part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the department a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Parts 3, 3.2, 3.6, and 4 of this Division. For purposes of this Part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The department shall identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The Mental Health Planning Council shall advise the Department of Mental Health on education and training policy development and provide oversight for the department's education and training plan development.

(b) The Department of Mental Health shall work with the California Mental Health Planning Council so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Department of Mental Health shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, Masters Degrees, or Doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Parts 3, 3.2, 3.6, and 4.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SECTION 9. Part 3.2 Commencing with Section 5830 is added to Division 5 of the Welfare and Institutions Code to read:

Part 3.2 Innovative Programs

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services.

(b) County mental health programs shall receive funds for their innovation programs upon approval by the Mental Health Oversight and Accountability Commission.

SECTION 10. Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code to read:

PART 3.7. OVERSIGHT AND ACCOUNTABILITY

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3, the Adults and Older Adults Systems of Care Act; Part 3.1, Human Resources; Part 3.2, Innovative Programs; Part 3.6, Prevention and Early Intervention Programs; and Part 4, the Children's Mental Health Services Act. The Commission shall replace the advisory committee established pursuant to Section 5814. The Commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county Sheriff, a Superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the Commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the Commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Develop strategies to overcome stigma and accomplish all other objectives of Parts 3.2, 3.6 and the other provisions of the Act establishing this Commission.

(6) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(7) If the Commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the Department of Mental Health pursuant to Section 5655.

5846. (a) The Commission shall annually review and approve each county mental health program for expenditures pursuant to Parts 3.2 for Innovative Programs and Part 3.6 for Prevention and Early Intervention.

(b) The department may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the Commission or when local programs could benefit from technical assistance for improvement of their plans submitted pursuant to Section 5847.

(c) The Commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

5847. Integrated Plans for Prevention, Innovation and System of Care Services.

(a) Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6.

(2) A program for services to children in accordance with Part 4 to include a program pursuant to Chapter 6 of Part 4 of Division 9 commencing with Section 18250 or provide substantial evidence that it is not feasible to establish a wrap-around program in that county.

(3) A program for services to adults and seniors in accordance with Part 3.

(4) A program for Innovations in accordance with Part 3.2.

(5) A program for technological needs and capital facilities needed to provide services pursuant to Parts 3, 3.6 and 4. All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the Education and Training Programs established pursuant to Part 3.1.

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults and seniors that it is currently serving pursuant to Parts 3 and 4 during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(b) The department's review and approval of the programs specified in paragraphs (1) and (4) shall be limited to ensuring the consistency of such programs with the other portions of the plan and providing review and comment to the Mental Health Services Oversight and Accountability Commission.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (a) shall include services to address the needs of transition age youth ages 16 to 25.

(d) Each year the Department of Mental Health shall inform counties of the amounts of funds available for services to children pursuant to Part 4 and to adults and seniors pursuant to Part 3. Each county mental health program shall prepare expenditure plans pursuant to Parts 3 and 4 and updates to the plans developed pursuant to this Section. Each expenditure update shall indicate the number of children, adults and seniors to be served pursuant to Parts 3 and 4 and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(e) The department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the proposed number of children, adults and seniors pursuant to Parts 3 and 4; the extent to which there is an unmet need to serve that number of children, adults and seniors; and determine the amount of available funds; and provide each county with an allocation from the funds available. The department shall give greater weight for a county or a population which has been significantly underserved for several years.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (6) of subdivision (a) for services pursuant to paragraphs (2) and (3) of subdivision (a) in years in which the allocation of funds for services pursuant to subdivision (c) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

5848. (a) Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30–day comment period required by subsection (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The department shall establish requirements for the content of the plans. The plans shall include reports on the achievement of performance outcomes for services pursuant to Parts 3, 3.6 and 4 funded by the Mental Health Services Fund and established by the department.

(d) Mental health services provided pursuant to Parts 3 and 4 shall be included in the review of program performance by the California Mental Health Planning Council required by Section 5772(c)(2) and in the local mental health board's review and comment on the performance outcome data required by Section 5604.2(a)(7).

Section 11. Section 5771.1 is added to the Welfare and Institutions Code to read:

5771.1 The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the Council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the Council specified in Section 5771.

SECTION 12. Section 17043 is added to the Revenue and Taxation Code to read:

17043. (a) For each taxable year beginning on or after January 1, 2005, in addition to any other taxes imposed by this part, an additional tax shall be imposed at the rate of 1% on that portion of a taxpayer's taxable income in excess of one million dollars ($1,000,000).

(b) For purposes of applying Part 10.2 (commencing with Section 18401), the tax imposed under this section shall be treated as if imposed under Section 17041.

(c) The following shall not apply to the tax imposed by this section:

(1) The provisions of Section 17039, relating to the allowance of credits.

(2) The provisions of Section 17041, relating to filing status and recomputation of the income tax brackets.

(3) The provisions of Section 17045, relating to joint returns.

SECTION 13. Section 19602 of the Revenue and Taxation Code is amended to read:

19602. Except for amounts collected or accrued under Sections 17935, 17941, 17948, 19532, and 19561, and revenues deposited pursuant to Section 19602.5, all moneys and remittances received by the Franchise Tax Board as amounts imposed under Part 10 (commencing with Section 17001), and related penalties, additions to tax, and interest imposed under this part, shall be deposited, after clearance of remittances, in the State Treasury and credited to the Personal Income Tax Fund.

SECTION 14. Section 19602.5 is added to the Revenue and Taxation Code to read:

19602.5 (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Beginning with fiscal year 2004-2005 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004-2005, the applicable percentage shall be 0.70 percent.

(3) Beginning with fiscal year 2006-2007, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the Act establishing this section.

(c) No later than March 1, 2006, and each March 1st thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1% imposed under Section 17043, as reflected on the original returns filed by October 15th of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1st of the year that is two (2) years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

Tax Year	Estimated Tax Liability Increase from the Additional Tax
2005	$ 634 million
2006	$ 672 million
2007	$ 713 million
2008	$ 758 million

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of seven (7) percent to the "estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

Applicable Fiscal Year	Estimated Revenue From Additional Tax
2004-05	$ 254 million
2005-06	$ 683 million
2006-07	$ 690 million
2007-08	$ 733 million

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007-08 and each applicable fiscal year thereafter shall

be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two (2) years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than ten (10) business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

SECTION 15. Part 4.5 (commencing with Section 5890) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.5. MENTAL HEALTH SERVICES FUND

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The Fund shall be administered by the department of Mental Health. Notwithstanding Section 13340 of the Government Code, all monies in the Fund are continuously appropriated to the Department, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this Division:

(1) Part 3 commencing with Section 5800, the Adult and Older Adult System of Care Act.

(2) Part 3.6 commencing with Section 5840, Prevention and Early Intervention Programs.

(3) Part 4 commencing with Section 5850, the Children's Mental Health Services Act.

(b) Nothing in the establishment of this Fund, nor any other provisions of the Act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this Act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing such obligations of plans and insurance policies.

(c) Nothing in this Act shall be construed to modify or reduce the existing authority or responsibility of the Department of Mental Health.

(d) The Department of Health Services, in consultation with the Department of Mental Health, shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults and seniors for medically necessary care.

(e) Share of costs for services pursuant to Parts 3 and 4 shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless such Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Parts 3 and 4.

5891. The funding established pursuant to this Act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this Act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

5892. (a) In order to promote efficient implementation of this Act allocate the following portions of funds available in the Mental Health Services Fund in 2005-06 and each year thereafter:

(1) In 2005-06, 2006-07, and in 2007-08 10% shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10% for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) 20% for Prevention and Early Intervention Programs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association pursuant to Part 3.6. Each county's allocation of funds shall be distributed only after its annual program for expenditure of such funds has been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(4) The allocation for Prevention and Early Intervention may be increased in any county which the department determines that such increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The statewide allocation for Prevention and Early Intervention may be increased whenever the Oversight and Accountability Commission determines that all counties are receiving all necessary funds for services to severely mentally ill persons and have established prudent reserves and there are additional revenues available in the Fund.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 for the Children's System of Care and Part 3, for the Adult and Older Adult System of Care.

(6) 5% percent of the total funding for each county mental health program for Parts 3, 3.6 and 4 shall be utilized for Innovative Programs pursuant to an approved plan required by Section 5830 and such funds may be distributed by the department only after such programs have been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(b) In any year after 2007-08, programs for services pursuant to Parts 3 and 4 may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20% of the average amount of funds allocated to that county for the previous five years pursuant to this Section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of such costs shall not exceed 5% of the total of annual revenues received for the Fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Parts 3 and 4.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), the department shall also provide funds for the costs for itself, the Mental Health Planning Council and the Oversight and Accountability Commission to implement all duties pursuant to the programs set forth in this section. Such costs shall not exceed 5% of the total of annual revenues received for the Fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Parts 3, 3.6 and 4.

(e) In 2004-05 funds shall be allocated as follows:
(1) 45% for Education and Training pursuant to Part 3.1.
(2) 45% for Capital Facilities and Technology Needs in the manner specified by paragraph (2) of subdivision (a).
(3) 5% for Local Planning in the manner specified in Subdivision (c) and
(4) 5% for State Implementation in the manner specified in subdivision (d)

(f) Each county shall place all funds received from the state Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on such investments shall be transferred into the Fund. The earnings on investment of these funds shall be available for distribution from the Fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the Fund and available for other counties in future years, provided however, that funds for

capital facilities, technological needs or education and training may be retained for up to ten years before reverting to the Fund.

(i) If there are still additional revenues available in the fund after the Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this Section, including all purposes of the Prevention and Early Intervention Program, the Commission shall develop a plan for expenditures of such revenues to further the purposes of this Act and the Legislature may appropriate such funds for any purpose consistent with the Commission's adopted plan which furthers the purposes of this act.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The Fund shall be increased by its share of the amount earned on investments.

5894. In the event that Parts 3 or 4 are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 or Part 4 of this Division are repealed or modified so the purposes of this Act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the Department of Mental Health shall implement the mental health services provided by Parts 3, 3.6 and 4 of this Division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Parts 3, 3.2, 3.6 and 4 of this Division through the annual county mental health services performance contract, as specified in Part 2, Chapter 2, Section 5650 et seq.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific time-line to achieve improvements.

(e) Contracts awarded by the Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission pursuant to Parts 3, 3.1, 3.2, 3.6, 3.7, 4, and 4.5 may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the department

of the anticipated county matching funds needed for community mental health programs.

5898. The department shall develop regulations, as necessary, for the department or designated local agencies to implement this Act. In 2005, the director may adopt all regulations pursuant to this Act as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 2 of Title 2. For the purpose of the Administrative Procedure Act, the adoption of regulations, in 2005, shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall not be subject to the review and approval of the Office of Administrative Law and shall not be subject to automatic repeal until final regulations take effect. Emergency regulations adopted in accordance with this provision shall not remain in effect for more than a year. The final regulations shall become effective upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SECTION 16

The provisions of this Act shall become effective January 1 of the year following passage of the Act, and its provisions shall be applied prospectively.

The provisions of this Act are written with the expectation that it will be enacted in November of 2004. In the event that it is approved by the voters at an election other than one which occurs during the 2004-05 fiscal year, the provisions of this act which refer to fiscal year 2005-06 shall be deemed to refer to the first fiscal year which begins after the effective date of this Act and the provisions of this Act which refer to other fiscal years shall refer to the year that is the same number of years after the first fiscal year as that year is in relationship to 2005-06.

SECTION 17

Notwithstanding any other provision of law to the contrary, the department shall begin implementing the provisions of this Act immediately upon its effective date and shall have the authority to immediately make any necessary expenditures and to hire staff for that purpose.

SECTION 18

This Act shall be broadly construed to accomplish its purposes. All of the provisions of this Act may be amended by a 2/3 vote of the Legislature so long as such amendments are consistent with and further the intent of this Act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures for the collection of the tax surcharge imposed by Section 16.

SECTION 19

If any provision of this Act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.

CONTRA COSTA COUNTY
MENTAL HEALTH COMMISSION
Diversity and Recruitment Workgroup

Approved Mission Statement

The mission of the Diversity and Recruitment Workgroup is to advise, guide and support the Mental Health Commission and members of the Board of Supervisors in order to recruit, select, orient, educate and retain Commissioners who collectively:

- reflect, represent, respect and embrace the cultural and socio-economic diversity of Contra Costa County; and
- contribute a variety of expertise, perspectives and experience with the local mental health system.

MHC Focus Area Action Plan 2010
Focus Area #4 - Diversity and Recruitment Workgroup

- Increase consumer voice
- Reflect mission statement
- Cultural, racial, ethnic, social group diversity

Specific Areas of Interest

Recruitment

- Identify disenfranchised or underrepresented groups;
- Provide education on who the MHC is, what we do, and how candidates can be an important part of the Commission through Commissioner networking and presentations, written marketing materials and electronic media (such as website, Facebook, Twitter, LinkedIn, etc.);
- Revisit MHC application to ensure that it does not exclude diversity participation;
- Generate and sustain long-term community enthusiasm for participation in the MHC;
- We are not looking to reinvent the process, but rather to realign the existing process and enhance the diversity already built into the MHC (geographic, consumer/family/at-large mandated mixture).

Selection

- Clearly set forth expectations for candidates;
- Devise a professional interview process to ensure that questions are thoughtful, relevant and presented in a non-discriminatory manner and train commissioners on appropriate interview techniques;
- Partner with our Board of Supervisors to understand their individual selection criteria and assist in assuring that MHC and BOS selection processes dovetail, and do not conflict, with each other.

Orientation and On-Boarding

- Timely commissioner training, with flexibility for commissioners who are employed or have transportation issues;
- Provide user-friendly commissioner orientation binder;
- Assign a mentor;
- Have a standard list of commissioner resources - key websites and sources of information, list of people to know in the Contra Costa mental health community; list of current MHC topics of interest, etc.

Retention

- Demonstrate, both in actions and words, a high level of respect for fellow commissioners and members of the public;
- Give new commissioners responsibilities but don't throw them in the deep end of the pool by themselves;
- Commission leadership touches base frequently and keeps a finger on the pulse of individual commissioner needs in order to maintain energy and enthusiasm - deal with frustration proactively;
- Conduct exit interviews with departing commissioners;
- Commit to assisting commissioners in overcoming personal obstacles - transportation issues, disability issues, etc.

On-Going Action Items for Workgroup which do not require MHC Approval

1. Contact other county MHC to see how they address the diversity issue - determine if they have marketing materials, specific interview questions, look at website, find out what other resources have they used to assist in the inclusion process.
2. Determine what resources are available to other Contra Costa County commissions and committees to accommodate members and visitors with challenges - include close captioned videotaping of meetings, audiophones, changing the size of the text on our website, translation services.
3. Create a list of underrepresented communities within Contra Costa County and pre-existing organizations serving those communities which can be leveraged for greater MHC exposure.

Action Items for MHC Meeting - April 8, 2010

1. Understanding that how we conduct ourselves in public meetings can disincent someone to join the MHC, commissioners affirmatively commit to conduct themselves in a respectful, professional manner.

2. Authorize the Chair to designate an individual/individuals to conduct exit interviews for Commissioners who have left in the last two years and further authorize the Workgroup to develop a set of exit interview questions designed to enhance our understanding of our current diversity challenges and opportunities.

3. Encourage all commissioners to privately speak with the Chair and/or Vice-Chair if there is a disability which prevents them from fully participating in MHC meetings.