CONTRA COSTA
HEALTH SERVICES

30 Douglas Drive, Suite 240
Martinez, California 94553
Ph (925) 372-4439
Fax (925) 372-4438

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION

Thursday • May 13, 2010 • 4:30-6:30 p.m.

Concord Police Department Community Room • 1350 Galindo Street • Concord

The Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings who contact the Executive Assistant at least 48 hrs. prior to the meeting at 925-957-5140.

AGENDA

Public Comment on items listed on the Agenda will be taken when the item is discussed.
Times are approximate; items may be taken sooner than noted or out of the order listed.

1. 4:30 **CALL TO ORDER / INTRODUCTIONS**

2. 4:40 **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. 4:50 **ANNOUNCEMENTS**
A. Behavioral Health Rapid Improvement Event - Friday, May 14th at 10am, CCRMC

4. 5:00 **CONSIDER APPROVAL OF MINUTES**
April 5, 2010 Public Hearing MHSA 2010/2011 Annual Plan Update
April 5, 2010 Public Hearing MHSA Capital Facilities Project Proposal
April 8, 2010 MHC Monthly Meeting

5. 5:10 **REPORT: MENTAL HEALTH DIRECTOR – Donna Wigand**

6. 5:20 **CHAIRPERSON'S COMMENTS – Peter Mantas**
A. Consider update on Board of Supervisors Internal Operations Committee
B. Clarification of emergency agenda item added at April MHC meeting.
C. Commissioner Update:
   1. Annis Pereyra will seek re-appointment for District II
   2. Anne Reed will not seek re-appointment for District II

3. Consider approval of Commission Candidates recommended by Executive Committee
    a. Peggy Kennedy, District III, Member-At-Large, through 6/30/13
    b. Peter Bagarozzo, District V, Family Member, through 6/30/13
    c. Evelyn Centeno, District II, Member-At-Large, through 6/30/13
4. Workgroups Comment by Commissioner Yoshioka

7. 5:35 **MHC COMMITTEE / WORKGROUP REPORTS**

A. Bylaws Workgroup Update – Peter Mantas
    a. Review the Workgroup's recommendation in response to County Counsel's recommendations on the Commission's approved bylaws amendments
    b. Consider approval of the workgroup's recommendations
B. MHC Capital Facilities and Projects/IT Workgroup –Annis Pereyra
    a. Review the Workgroup's report and recommendation
    b. Consider approval of the Workgroup's recommendations
C. Quality of Care Workgroup – Carole McKindley-Alvarez
    a. Review the Workgroup's report and recommendation
    b. Consider approval of the workgroup's recommendations
D. Diversity and Recruitment Workgroup – Anne Reed
    a. Review the Workgroup's report and recommendation
    b. Consider approval of the workgroup's recommendations

8. 6:10 **REPORTS: ANCILLARY BOARDS/COMMISSIONS**

A. Mental Health Coalition – Teresa Pasquini
B. Human Services Alliance – Mariana Moore
C. Local 1 – John Gragnani
D. Mental Health Consumer Concerns (MHCC) - Brenda J. Crawford
E. National Alliance on Mental Illness (NAMI) – Al Farmer
F. MHSA CPAW – Annis Pereyra

9. 6:20 **FUTURE AGENDA ITEMS**

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

A. Suggestions for June Agenda ***[CONSENT]***
    1. Anna Roth (CEO CCRMC – Update)

B. List of Future Agenda Items:

1. 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
2. Rose King Presentation on MHSA
3. Behavioral Court Presentation
4. Case Study
5. Discussion of County Mental Health Performance Contract & Service Provider Contract Review.
6. Presentation from The Clubhouse
7. Discuss MHC Fact Book
8. Review Meetings with Appointing Supervisor
9. Creative ways of utilizing MHSA funds

10. TAY and Adult's Workgroup
11. Conservatorship Issue
12. Presentation from Victor Montoya, Adult/Older Adult Program Chief
13. Presentation from Crestwood Pleasant Hill
14. Presentation on Healthcare Partnership and CCRMC Psych Leadership
14. Presentation on non-traditional mental health services under the current PEI MHSA programs

10. 6:30 **ADJOURN MEETING**

The next scheduled meeting will be Thursday, June 10, 2010 from 4:30- 6:30 pm at the Concord Police Department.

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

Contra Costa Mental Health Commission
Public Hearing-MHSA 2010/2011 Annual Plan Update
4/5/10
Minutes – Draft

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 4:40 pm by Chair Mantas.

Commissioners Present:
Dave Kahler, District IV
Peter Mantas, District III, Chair
Carole McKindley-Alvarez, District I
Colette O'Keeffe, MD, District IV
Floyd Overby, MD, District II
Annis Pereyra, District II
Teresa Pasquini, District I

Commissioners Absent:
Supv. Gayle Uilkema, Dist. II
Anne Reed, District II
Sam Yoshioka, District IV

Attendees:
Brenda Crawford, MHCC
Helen Geddes
Tom Gilbert, Shelter Inc.
Ralph Hoffmann, NAMI
Connie Steers, MHCC
Janet Marshall Wilson, MHCC

Staff:
Donna Wigand, MHA
Suzanne Tavano, MHA
Vern Wallace, MHA
Sherry Bradley, MHA
Mary Roy, MHA
Susan Medlin, MHA
Holly Page, MHA
Erin McCarty, MHA
Caroline Sison, MHA
Cindy Downing, MHA

Sherry Bradley had the translators from IEC introduce themselves: Thu-Thuy Trinh-Vietnamese, Marcela Morales-Spanish and Barry Barlow-American Sign Language. They will be here for the duration of this public hearing.

Introductions were made around the room.

2. OPENING COMMENTS BY MENTAL HEALTH COMMISSION (MHC) CHAIR

3. MHSA DRAFT 2010/2011 ANNUAL UPDATE TO THE 3-YEAR PROGRAM AND EXPENDITURE PLAN by MHSA Program Manager Sherry Bradley and Prevention and Early Intervention Project Manager Mary Roy

Today's public hearing is for the MHSA Annual Plan Update for 2010/2011.
(PowerPoint handout follows the minutes)

Guidelines for MHSA funding come from Department of Mental Health (DMH) notices. The reason for the push to approve the plan and seek funding is the notice for this update was issued in January, approx. 4 months late.

The DMH notices rolled out each set of Component guidelines in a staggered manner. The first one was Community Support and Services (CSS). Each subsequent notice (Prevention and Early Intervention, Workforce Education and Training) had different terms which were confusing. The recent guideline made the terms consistent for all plans.

Contra Costa County is seeking funding for CSS, PEI and WET through this update, but not Innovation, Capital Facilities or Technology Needs because those are sought through a separate process. By 6/2012, DMH will issue guidelines that will truly integrate the Annual Plan to include all of the components. Funding will be sought for all components, at the same time, on an annual basis. The Annual Update will contain activities reports for WET, but not a funding request because WET funds were received for 10 years.

The allocations sought for CSS are $17,715,700.00 and for PEI $5,016,100.00. The handout showed an Innovation funding request of $2,719,300.00, but that is not being sought through this plan.

Based on the DMH Guidelines, when an Update is prepared, funding is based on Activities Reports and Outcome Reports for a specific, previous year. For instance, this 2010/2011 Update reports on activities for 2008/2009.

A full blown planning process is no longer required as this is a Plan Update, an update to the initial 3 year Plan. The initial 3 year plan was for 2005/2006, 2006/2007 and 2007/2008.

The packet contains descriptions for CSS, PEI and WET programs and a budget summary form for each. There are also Outcomes and Indicators for PEI (2008/2009)

Holly Page presented CSS 2008/2009 Outcomes and updates on hospitalizations related to Full Service Partners (FSP).

(PowerPoint handouts follows the minutes.)

Outreach and Engagement is reported to the state every quarter; the entire fiscal year is shown in the handout. There was much less outreach for potential FSP's for adults because the program is at capacity. FSP enrollment is at capacity for Adults and increasing for Children, TAY and Older Adults. Most of the Housing for FSP's is for adults. She reviewed 2008/2009 Outcomes for FSP Program Capacity, Demographics, Employment, Arrests and Incarceration, School Grades, School Attendance and Hospitalizations on a Pre-Enrollment and Post-Enrollment basis.

She reviewed hospitalization rates for FSP's vs. System of Care (SOC) patients. The two populations have many variables making accurate comparisons challenging. The average length of stay for current FSP's and SOC patients is approximately the same (8 days), but when current FSP's are compared to the SOC patients prior to program intervention, they had significantly higher hospitalization utilization.

Commissioner O'Keeffe suggested it would be helpful to see statistical significance noted in the data analysis. Holly Page said that could be shown in the future.

Commissioner McKindley-Alvarez said she appreciated the information that the qualifications to become a FSP are so different because that population utilized services more than SOC

people. Although the numbers presented may not look significant, they are when it is considered who the FSP population is.

Vice Chair Pasquini said while she appreciates the data shows improvements in outcomes for FSP's, she was interested in those people that aren't getting into FSP programs that are at serious risk and still cycling in and out of hospitals as well as those in FSP programs that are still struggling. She has grave concerns about the care being given under the FSP programs and has emails she would like to attach as public comment concerning a specific consumer that she wonders if may be representative of issues going on. There are SOC consumers who are not receiving care and she would like that reflected in the data. She would like to know who is not getting served with enhanced services, reflecting the two-tiered system.

Suzanne Tavano said the criteria for hospitalization (5150) are the same for FSP and SOC population, but overall the FSP's have more issues going on.

Donna Wigand clarified Vice Chair Pasquini is looking to find out how many other consumers in the SOC population, who meet the FSP qualifications, but are not but are not receiving those same services because they are unable to access the system. Sherry Bradley said there may be a capacity issue. Suzanne Tavano said MHA recently approached CSU staff to work together to gain a better understanding of non-FSP's who are having many visits to CSU and multiple hospitalizations and see what those numbers are.

Commissioner Kahler agreed with Vice Chair Pasquini's comments.

Chair Mantas agreed as well, but this venue may not be the best place for the discussion. The Quality of Care Workgroup will taking up the issues of level of care (dual system for FSP's vs. SOC) and reviewing the data in more depth.

Vice Chair feels it is appropriate to talk about the effectiveness of current programs and a general concern how MHSA funds are addressing consumers in crisis in CCC.

Mary Roy presented PEI information for 2008/2009. RFP's were issued, contracts negotiated and contracts awarded, but nothing had been launched during that time period. She reviewed the Projects, and Programs within each, MHSA PEI funds were being utilized for.

(Information chart already included in the Draft Plan made available during the Public Comment period.)

All the programs have measures and outcomes by which they will be evaluated. 3rd quarterly reports are due soon. Mary Roy has visited each program.

Commissioner O'Keeffe noted the Clubhouse receives funding and serves a smaller population and wondered if MHCC, with 3 locations, receives greater per capita funding? Donna Wigand said MHCC's expanded funding for their 3 centers comes through CSS not PEI. Commissioner O'Keeffe asked if MHCC's funding was proportionally larger based on the larger population served? Donna Wigand did not know that level of detail, but MHCC's funding is not based on number of people coming through the door, but hiring staff to enrich the programs available for consumers already coming in.

Suzanne Tavano said the contract for MHCC is larger than the Clubhouse.

TO DO: Staff to follow up on per capita funding (per person served) amount per program.

Mary Roy clarified there are only 2 programs not yet launched and they are county run programs. The hold-up for creating and hiring for the positions is in downtown HR, due to the hiring freeze on until 7/1/10. Suzanne Tavano said these positions are not on the priority list for creation. Chair Mantas confirmed 75% of the funding was received late fall/early winter 2009, but the hiring issues keep coming up. Maybe the MHC should take a position on this to the BOS.

The scope of services and contract amounts are listed on the PEI website; Sherry Bradley offered to send out the document.

(The list of PEI Awardees with a summary of scope of services and contract amounts per program is listed at: http://www.cchealth.org/services/mental_health/prop63/pdf/pei_awardees_by_project.pdf)

(A list of PEI Awardees and a detailed scope of services and facility information for each program is available at: http://www.cchealth.org/services/mental_health/prop63/pdf/2010_scope_of_services_facility_info.pdf.) Contract amounts are not listed.

Caroline Sison presented WET activity updates. The overall program is to encourage a well trained and diverse workforce to support better health outcomes for mental health consumers. The Workforce Staffing Support and Training and Technical Assistance target current employees while Mental Health Career Pathway, Residence/Intern and Financial Incentive Programs target potential employees. *(Handouts follow the minutes)*

Sherry Bradley noted the Activities handout shows 16 staff trainings; there were actually 23 trainings for staff and CBO's. Vice Chair Pasquini was interested in how many MHA administration staff vs. line staff were trained. Sherry Bradley said it depended on what type of training it was, but that information is available in a chart form.

TO DO: Staff to follow-up with Carolyn Sison to obtain the chart.

Commissioner O'Keeffe asked if WET training is only for official mental health workers or could it be expanded to include employees in ambulatory care so they can be educated in the physical/medical needs of consumers who are underserved at this point?

Donna Wigand said MHSA funds are unable to be used to train medical providers is not possible. She read one synopsis of the federal Healthcare Reform Act and it included funding for that type of training and is supposed to be implemented by 2014.

Vice Chair Pasquini asked about the Family training. Carolyn Sison clarified it was for Children in 2008/2009 and Adult training is being planned. Sherry Bradley said MHA does not currently have a WET or Ethnic Services Manager; therefore, some of these initiatives are on

hold. There have been several strategies suggested for Family Member Employment to meet those needs. Gloria Hill was reviewing different curriculums to determine if CCC would like to develop its own program, along the lines of SPIRIT (requiring a college course and internship). There are 3 open positions for Family Coordinator, one in each region, and training must be completed as part of the job specifications. Training has been developed on the Children's side, but not yet for Adults.

Vice Chair Pasquini asked if the training for Adults is Family to Family? Donna Wigand said it states Family to Family or some other equivalent program.

Commissioner McKindley-Alvarez what percentage of the funds go directly to the training of consumers? It looks like most of the funds go toward training people who work with consumers vs. self-identified consumers training for gainful employment. Susan Medlin said funds come from WET, CSS and PEI. Different positions are funded differently and from various contracts. Commissioner McKindley-Alvarez asked if the discussion could be held during the comment portion of the hearing about what the WET program is doing to increase consumer employment since that is an area with struggling outcomes?

Donna Wigand said although Actions #4 and #7 target consumers as potential County employees, programs like the Clubhouse and MHCC enrichment train consumers as potential members of the general workforce.

Susan Medlin mentioned the PSI classes they are trying to get at CC College are meant to enable consumers to look beyond a Community Support Position.

4. PUBLIC COMMENT ON PLAN

Ralph Hoffman: Thank you. I started in last October getting involved in the process and I did not get into the details of the plan, but I am looking approve of the plan as it stands. I would like to make two comments regarding the forums. First, commission meetings and hearings may want to consider sending agendas via email not US mail to save money and make internet links easier to get to access, (he mentioned that Alcohol and Other Drugs Advisory Board does this). Second, he questioned this location for public forums. There are translators and people that are transit-depend who maybe don't know that transit lines to this location ends at 8pm. Concord police station is more favorable for those who are transit depend, especially because it is easily accessible by BART.

Chairperson Mantas: Thanked Mr. Hoffman for his comment. The issue with selecting this location is more about availability, but we are definitely looking into more options.

Brenda Crawford: I know that the Workforce Education & Training money has specific restrictions on it, it's to train folks to work within our system. As Donna said earlier, there are people at our wellness and recovery centers who are getting trained on computers and improving their technical skills so that they are able to market themselves outside of our system, but I think we need to look at what the needs are within our system and then expand our definition of having consumers work in growing areas of mental health, which is Aging and Older Adult. I have been a proponent of training consumers to work with older adult consumers who are in the mental health system and training them as home health care aids and then having them able to provide the kind of services that seniors need to stay healthy and engaged as they go through this aging process. Also, it'd take up a lot of slack that in home supportive services has fallen

off in terms of them being defunded. It's a growing field, one of the biggest insurance products going right now is long term health insurance, because people want to age in their homes and they want to be able to stay vital and alive and they need the support of people in order to do that. We had a project called TLC that was funded for consumers to work with other consumers around issues that would allow folks to be productive and stay in the home, such as shopping and that kind of thing. We are looking to revitalize that program. I would encourage us to look at WET and look at the system and a population that is growing and to also fund a program like this is inter-generational training for younger consumers to partner up with older consumers and it would be win/win for everyone. Thank you.

Ralph Hoffman: Supports what Brenda says, I am very familiar with this, and we actually have to import immigrants from Latin America and Asia because we don't have, in this country, enough people licensed as CNAs or HHAs. This would be an excellent type of training. It is very important to pay attention to elder financial abuse, that is a very big issue in our state and nation, and it is similar to domestic violence. Both are rising crimes and elder financial abuse is a particularly rising crime.

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5. **CLOSE PUBLIC COMMENT ON PLAN**

6. **MHC COMMENT ON THE PLAN**

Chairperson Mantas closed the public comment phase of the agenda and opened up for Commissioner's comments.

Commissioner Kahler: What emphasis was placed on serious and chronic mental illness? It seems to me that going back to Rose King's objections to a 2-tiered system, that we're addressing ourselves to the worried well, without even making a pretense of addressing the needs of serious and chronic mental illness, which it seems to me that's what the Mental Health Commission and Mental Health Administration is all about. And some philosophy in the way that Prop 63 came together in the form of MHSA is this expression of the 'unserved'. We have people at the core who are unserved. You don't have to go anyplace to find unserved people in the mental health system. And some of the listing that Mary had up there are clearly not involved with and have no history of dealing with serious and chronic mental illness. It was a year ago, and I never heard anything from the Commission or Administration in response to Rose King who was speaking against the unique aspects of Prop 63 and the two-tiers. We haven't gotten the first tier going.

Mental Health Director: Rose King was expressing discomfort at a state level as well, it wasn't just to this county. She was expressing that discomfort that a lot of us feel, to Sacramento and to the folks who wrote the language in Prop 63. I think most of the Commissioners know, but there may be some in the room that do not know, that PEI money has to be spent with very strict guidelines, which we didn't write, about going into communities that are not traditional mental health communities, at all. They are not traditional SPMI and doing the kinds of activities that enhance their protective factors vs. risk factors. Dave, I hear your frustration. Until those silos are taken off, we have to spend the money how the state tells us to spend the money.

Commissioner Kahler: Definition on early prevention of people trying to get into a clinic in East County and waiting 8 months on a list; why couldn't that be defined 'early intervention', recognizing a problem in the early stages, instead of going out into another part of the community, literarily as people who would be defined as the worried well, which they have problems and they should be sympathized with but I think when you're having money problems, you're not prioritizing correctly to go out to another community. I understand it all comes from the original Prop 63, but then we hear about other counties that have done it, where they have spent Prop. 63 money to address serious and chronically mentally ill clients.

Mental Health Director: One of the things this Commission could do then is to invite the original stakeholder planning group, because there wasn't any individual in this room that put this plan together and submitted it for approval to the state, which was approved. There was a stakeholder planning process that involved many folks and lots of time and maybe one of the things the Commission could do is to invite folks to come in and do a presentation to the Commission about how those decisions were made. Doesn't mean you'll necessarily like it and I know that.

Commissioner McKindley-Alvarez: I'm unclear what we're trying to do today. Now that we've gotten this information, are we trying to see whether or not we support the plan moving forward as it stands with all information we've been presented?

Chairperson Mantas: Yes

Commissioner McKindley-Alvarez: So the places where we could challenge the plan within the parameters of Prop 63 guidelines are around shifting some of the strategies that have been proposed?

Chairperson Mantas: If we believe the money is not being used properly, if we believe that the plan could be changed significantly to improve outcomes, this is the time. Or if it's minor comments, we can make those comments so that they can be substantive to minor changes or significant changes.

Commissioner McKindley-Alvarez: This is something that needs to be submitted by the 15th (April 15, 2010)?

MHSA Project Manager: In order to be funded by July1, 2010, the DMH guidelines state we'd need to be approved by April 15th.

Chairperson Mantas: The frustration over the timing of us reviewing it, is something that we'll be addressing shortly and figuring out how to improve the process and have intermediate steps to where CPAW presented stepping stones in plan development, so next time when we go through this process, a lot of these things are brand new.

Commissioner Kahler: One of the lessons of the county budget is I see us all get interested in March, and excited in April and psychotic in May, and all this is foolishness. We should be working on the budget for the following year. The stuff we are talking about here, we should have months ahead of time to develop some kind of a competent outlook on it.

MHSA Project Manager: We couldn't agree with you more.

Vice Chair Pasquini: My recollection was that we (on CPAW) were told we needed to push forward with this to avoid the governor raiding MHSA in another ballot initiative. We were told that was probably for sure going to happen. Then all the indicators disappeared after CPAW went ahead and passed and rolled this over. The time frame had to be accelerated so wouldn't have money at state, but have it in our county.

Commissioner Pereyra: Everything got pushed through in an expedited manner. That was the comment they kept making about rubber stamping things and not really investigating because the time frame had to be accelerated in order to get the funds here in Contra Costa County, so they (the funds) wouldn't be at risk in Sacramento.

Vice Chair Pasquini: So the rush on timing, since that is now gone. Although the budget's not settled, so we can always sit and wonder when Arnold is going to swoop down and threaten to take funds. But we know legally the governor can't take these funds right now, so they're not at risk if they're not approved.

Commissioner Kahler: That's not right. The State takes funds. Legally they can't take them, but they do take them routinely.

Vice Chair Pasquini: They are not taking Prop 63 funding without going to the voters.

Commissioner Kahler: It is conceivably possible.

Vice Chair Pasquini: They would have to change the law to do it.

Commissioner Pereyra: That's why it would have needed another ballot initiative to change the law, and then he very well would have raided the funds. He stated that he would, Meg Whitman has stated that she will. There are a lot of people who would like to (raid the funds).

Commissioner Kahler: They are desperate and unscrupulous.

MH Deputy Director: One thing they can do, they are already talking about, is suspending payment, which they don't need to have a ballot initiative to do.

MHSA Project Manager: Is that the cash deferral?

MH Deputy Director: Yes.

Mental Health Director: So they have already told us that they are going to defer $350 million of MHSA money to all counties. So whatever payment we should have gotten July 1 would be deferred. They have to pay us, at some point, but they are legally allowed to defer it. We end up with a cash flow problem, they haven't told us how, or how long, and it would start July 1st.

Vice Chair Pasquini: So there is still pressure, is what you're saying.

MHSA Project Manager: Correct. If this request doesn't get in by June 30th, they can defer payment. If this request for plan approval gets approved by the state after July 1 2010, there is every possibility that this money will be deferred and we wouldn't get money until July 2011.

Vice Chair Pasquini: I absolutely object to this process. I find it outrageous. The entire implementation process is wasteful: it's wasting time, it's wasting money, it's wasting lives. Yes, it's helping a handful of people that I'm delighted about, but I absolutely 100% oppose it. I personally suffer with rolling over and I've done it 2 times in CPAW. In CPAW, I think when we agreed to approve it, there were some conditions on the approval, if I'm not mistaken. There were conditions that we were going to be going back to review some of the work plans, within a time frame?

MHSA Project Manager: Yes, we would revisit the process, but I don't know if we set a timeframe. We were going to go back and look at those issues so we could be ready for the next round of plan review (for 2011/2012).

Vice Chair Pasquini: Whether I provide these emails or not, I have concerns about the Bridges to Home collaborative, that has been funded from the beginning of CSS. The plan that has been written and submitted to the state that we have been drawing down funds, and that we are about to draw down funds again, is not what it actually has been, and currently services provided are not as it was written in the plan. I haven't seen contracts or a work plan. Has the work plan changed?

MHSA Project Manager: Yes, the work plan was updated with this update.

Chairperson Mantas: What are some details, high level? Most of us don't know what's being discussed right now.

Vice Chair Pasquini: I don't know what's been changed. But I have been in many meetings where I heard the collaborative fell apart almost immediately and that peer support services have been a topic of conversation. I'm not comfortable with being the only Commissioner who's sat in these meetings and had these discussions and heard about it, and they haven't come forward

and talked about it with the Commission. I would want the Commission to be brought up to speed. I am very, very much opposed to those problems – if they have been worked out. I'd be happy to provide the Commission with these documents that I have. I've been waiting, I've written to Sherry, Donna, Suzanne, wanting to know how these issues are being resolved. They have been discussed in the CPAW Facilitator Selection committee. I assumed that these issues were being worked out and that Full Service Partners were actually receiving the wrap around support, and come to find out that's not the case. That was not the case in the situation that I had.

Brenda Crawford: I feel compelled to answer, since we're talking about peer support services which is the part of full service partners that MHCC is contracted to do. I was not here during the initial formation of the collaboration, but it's not unusual that people who have never worked together have to find their niche. And it's not that services weren't provided; wrap has always been provided at our Wellness and Recovery Centers. We just last week finished a new scope of work where we have allocated a number of hours that are being funded to the Full Service Partnership. The way services are being provided is different than the original concept of everybody being housed together, but it does not mean that because we did not live together, we did not provide the services. We have documentation in terms of the number of FSPs who were going to our Wellness and Recovery Centers on a daily basis. What we're doing now is working out the kinks around the referral system. Yes, there were problems. Yes, it's a new program. Yes, in terms of implementation, and people learning how to work together, there were problems. But that did not mean that there was anybody, ever, not providing those services. The coordination may have been a problem at one point, but that's even being resolved. Just finished a scope of work to be submitted to Holly and we're satisfied with how services will be provided and have been delivered all along. The original concept of people living together and working together was not the smoothest process, especially in blending clinical and recovery approaches. But that was a lesson learned. Even in the learning of those lessons, we were still providing those services, just not in-house, we were providing those at Wellness and Recovery centers and people were being referred to us all the time.

Mental Health Director: As time goes by, Commissioners may want to go more in depth on a particular program. Teresa, I hear what you're saying and this may be the Bridges to Home program for you. At any time, any Commissioner has ability to say I am not comfortable with the things that I'm hearing and I would like to ask for structured review. If the chair wants to say we've identified a program in MHSA that we want a more formal, structured review of, and the chair wants to assign a Commissioner to that process, and we do the process, I think that's very appropriate. It's one way of getting out of having to do all the work at a Public Hearing setting.

Chairperson Mantas: Teresa, you know exactly what's being discussed, and the rest of us have no idea of the specifics. Can you give us what was in the plan, and what didn't happen so the rest of us can understand?

Vice Chair Pasquini: I have a scenario: 'several agencies responded for MHSA Community Services and Supports funds to provide services to adults in West County through a model called Full Service Partnerships, Rubicon was the lead agency. Mental health Consumer Concerns provided consumer driven recovery support. Asian Pacific Psychological Services, Familias Unidas worked into this collaborative.' And I assumed that this was a collaborative, that everyone was working together, providing services. And Brenda is correct. This is nothing about MHCC, it is simply my concern about that fact that these programs were supposed be, and that's what MHSA is all about, consumer driven, family driven programs, collaborative working together. And I was disappointed to hear that wasn't happening.

Chairperson Mantas: Have groups pulled out of the collaborative?

Vice Chair Pasquini: That is my understanding that Familias Unidas is not even part of it.

Brenda Crawford: Haven't pulled out of the collaboration. One of the things we did is that we needed to be clear about each organization's roles and responsibilities in the collaborative. Never once did we stop providing services. We just stopped until we were very clear about our place at the table. We knew that we were responsible for peer to peer services and we always provided that. What I didn't understand was why I was going to meetings where they were talking about Medi-Cal billing when that's not relevant to my services. For a minute we stopped and we said, "let's take a look and see how these pieces fit together." My understanding now, is that there's one work plan.

Holly Page, Planner/Evaluator: MHCC has one work plan, and Bridges to Home has a work plan and works on the ACT model and that's CHAA, ANKA and Rubicon. Each agency specifically spells out what they are contributing to the collaboration.

Brenda Crawford: Familias Unidas is still part of the collaborative. All the organizations, MHCC, Anka, Shelter, Inc., are providing services. Partners in the collaborative hadn't ever lived together, or work together, and decided that best to be house separated in order to provide services best.

Vice Chair Pasquini: I wasn't suggesting that. All attempts to communicate have been respectful. I offered, as a Commission and as acting Chair, when I was acting Chair, to participate in any level in any process. I wasn't suggesting that peer supports weren't provided, but not provided as in the plan

MH Deputy Director: Five years ago, initially, the thinking at that time was to ensure cultural and linguistic competency in the program, collaboratives were encouraged. What we found soon after everything started rolling and the plans were approved, was that a number of consumers were Medi-Cal beneficiaries; you can't sub-contract Medi-Cal, so the concept of having a lead agency where money is funneled through wasn't going to hold up because one agency couldn't claim Medi-Cal on behalf of another agency. And there's a fair amount of Medi-Cal money that's being used in the FSP, in order to maximize the dollar amount that is available. This raised the question that if there isn't a lead agency where all the money is funneling through, does it still make sense to have them all housed together in one place. Or can we still be able to provide the linguistic and cultural competency by way of the other partners? Several months ago, we got together with all of the partners, to clarify the roles and responsibilities, etc. and at that time we clarified with MHCC the role of the Wellness and Recovery Center and whether they would be onsite with other programs or if participants would be going to the Wellness Center. It seems that we've sorted out a lot of those issues.

Commissioner McKindley-Alvarez: This goes back to my question of what we're supposed to be doing here. We have so much that we could actually be talking about. But what we're talking about isn't something that can be implemented into what they are designing or what they have designed. Which for me is I haven't had the opportunity to thoroughly evaluate whether or not the services we are delivering are efficacious for whomever they were designed to be delivered to. Within the work plan, and inside the Plan that's submitted to the state, is there something we have written in there that we can evaluate how effective these programs are, and that within that evaluation if we determine that these programs are not providing the services they need to be providing, can recommendation be made regarding support? Can we have that inside this plan, or are we just spinning our wheels, because literally we have to make a decision on something we haven't had enough time to look at and they need to send it off by the 15th.

Chairperson Mantas: You just made it happen.

Vice Chair Pasquini: I'm going on the record as saying I'm very uncomfortable with this part of the plan and the way it's been handled. Maybe the one consumer I know is the only one that has

had an issue. Her services have been far from peer supported and she has fallen from literarily every crack. I have had 2 case conferences with Rubicon and have requested assistance for several months. So I don't know how to address that. Whether it's just this one consumer? I highly doubt that it is.

Chairperson Mantas: I believe that since you brought up the issue of emails that they need to be made part of the record. Maybe CPAW and Quality of Care Work group commission should be made aware and look at it. I think it's important that we bring it to the next level.

Commissioner McKindley-Alvarez: Collette had to leave early, and she wanted to know what happened to the jail population? She felt like it was not present.

MHSA Project Manager: I'm not qualified to address that. It's a program issue and I'm the administrator, so I don't have that deep of level of detail.

Mental Health Director: If an individual is enrolled in any of the Full Service Partnerships and is incarcerated, they are not dis-enrolled if incarcerated. That is the whole thing about MHSA that is different from other systems. The jail mental health system in this county is not on par to the mental health system; it is in other counties. If one of our folks who is not enrolled in an FSP, we might lose them. In the FSP, the question is did that person stay in that FSP while they were incarcerated, and continue to contacted by their PSC and released with services continuing through wrap around. This is data that we collect and find out. Unfortunately, people often cycle through jail as the cycle through the hospital.

Chairperson Mantas: The jail population is targeted to be FSP?

Mental Health Director: They are not specifically targeted. Jail services are not a part of Mental Health Division money. Funding from the larger Health Services Department funds both jail Mental Health and jail Health.

Chairperson Mantas: Funding for WET was received in late fall of 2008 or 2009?

MHSA Project Manager: WET plan approved in May 2009. In about November 2009 WET money was received.

Chairperson Mantas: Specifically, did we receive funding in 2008 for any programs that are not up and running right now.

MHSA Project Manager: We received no WET funding in 2008 because we did not have an approved plan. Our plan wasn't approved until May 2009. And we only received 75% of the funding initially.

Chairperson Mantas: For PEI, did any funds come in, in 2008/2009? And if not, have they been applied to action yet?

MHSA Project Manager: We received no PEI money in 2008, we did not receive money until our plan was approved in February 2009, and we only received partial funding in late 2009, at the same time we got the WET funding. So you're asking if any of those funds are still sitting up there and not being used?

Chairperson Mantas: We received funding for programs that have not been launched yet because of issues that are hanging them up in HR?

MHSA Project Manager: Yes. The county is required to submit revenue and expenditure reports based on MHSA, done by DMH notices, by fiscal year, and are due in February in the next fiscal year, and done by components. If you go to the State Department of Mental Health, it has fiscal references and it will show you what's left and what we haven't spent yet for each fiscal year.

Chairperson Mantas then closed Commission Comments.

7. DEVELOP LIST OF SUBSTANTIVE COMMENTS AND RECOMMENDATIONS TO THE COUNTY MENTAL HEALTH

ADMINISTRATION (MHA) AND TO THE BOARD OF SUPERVISORS (BOS)
NOTE: The MHA does not have to follow the MHC's recommendations. However, the MHA must incorporate MHC recommendations as part of the adopted plan along with appropriate analysis.

- **ACTION: Motion made to approve the MHSA 2010/2011 Annual Plan Update with the provision that there be included program evaluation for efficaciousness, for qualitative and quantitative data, and look at qualifications of contractors. Additionally, on the condition that the Commission revisit the performance contracts and make recommendations as a Commission if it is believed that those contractors lack the capabilities to deliver on the contract, and on the minor conditions that substantive comments be brought up and included in the Plan by MHA. (M-McKindly-Alvarez/S-Overby/P, 5-1, Y- Kahler, Mantas, McKindley-Alvarez, Pereyra, Overby, N- Pasquini,)**
(Commissioner O'Keeffe left the meeting at 6:00 pm and did not vote)

Discussion:

Commissioner Kahler: The range of programs I see there are going far off field and not addressing the essential mission of Mental Health Administration and the Commission is supposed to be, which is serious and chronic mental illness and that's not to be taken lightly. We're trying to help people who need some kind of help, but the worried well is not the province of the Mental Health Administration.

Commissioner Overby: I got this plan over a month ago and I've spent several hours going through it and I got more confused every time I looked at it. There are so many different divisions that I'm not even aware of and there wasn't much information on how these things did work, so it was difficult to evaluate it.

Chairperson Mantas: I would recommend that we go ahead and approve the plan and follow through with what Carole recommended, that we look at qualitative and quantitative data, and develop a plan that will work with MHA and CPAW for us to see these plans in development phases instead of last minute. If it wasn't for the sheer fact that the County would lose a bunch of money, I would say I wouldn't approve the plan. I don't think we are getting the level of quantitative data that we should be. Even though DMH and the OAC may say that we have enough, I don't believe that we are. My thoughts are to go ahead and approve the plan as presented with the caveat that all the comments are substantive to be included in the plan and we as a Commission work collectively with MHA to develop a better process about this.

Commissioner Kahler: Why can't there be a line item veto? Why do we have to take all of these? There are some of these that are glaringly bad.

Chairperson Mantas: Such As?

Commissioner Kahler: Such as channeling money to agencies that really haven't got any experience in mental health, early prevention or otherwise, and they don't make any pretense otherwise.

Chairperson Mantas: Do you have an example?

Commissioner Kahler: I think Rainbow Coalition [Center] would be an outstanding example.

Chairperson Mantas: You mentioned one, any others?

Commissioner Kahler: Not right now.

Vice Chair Pasquini: I have concerns that the adult families aren't participating enough and I know it's not that Sherry's not reaching out through NAMI. I'm not feeling confident with where things are at. I'm willing to sit and talk and debate, and there was a lot of discussion in CPAW last week. I'm not comfortable with where things are at. A question to Donna Wigand is, if we didn't approve it, what would you do?

Mental Health Director: I don't know. I can't do knee jerk reaction. I would have to think about it and weigh a lot of risks and benefits. If there was a way for you to say, we want more discussion on this, and I would have consult with Sherry Bradley about time frames and maybe we could come back and have a break out group?

MHSA Project Manager: The drop dead date is April 15 according to the guidelines issued by DMH. I understand that CMHDA asked for some forgiveness on that, but I don't know if that's occurred yet.

Commissioner Pereyra: We can go back and change it (the Plan). Sherry always says that.

MHSA Project Manager: That is correct.

Commissioner Pereyra: I was a part of the PEI stakeholder process, years ago, before Sherry was here, and I was at a public meeting and I was appalled at some of the things I was told that they didn't want to discuss. For example, dual-diagnosis programming. I was told that if that's what I came to offer up, then they didn't want to hear from me.

Commissioner Overby: How much money are we looking to lose?

MHSA Project Manager: $17 million for CSS, $5 million for PEI, $22 million total.

Chairperson Mantas: We can do anything, and again we have to remember as a Commission, that our approval of the plan is a recommendation to MHA ultimately to the OAC and this is how we feel, and to the Board of Supervisors, that we believe this is a good plan.

MHSA Project Manager: The reason for specifically excluding one contractor, and that was for PEI contract?

Commissioner Kahler: Innovation.

MHSA Project Manager: No, Innovation isn't included for this Public Hearing. We did that.

Commissioner Kahler: I was responding to what Mary had up on the screen.

MHSA Project Manager: What is the basis of your line-item vetoing that one contract?

Commissioner Kahler: I am thinking serious and chronic mental illness and early intervention, and I don't see any possibility. I'm not saying anything against the people or the agency, but rather the qualifications for what MHA and the Commission is involved with, what our mission is. It's serious and chronic mental illness and not some strata of that.

MHSA Project Manager: If that's your definition, you'll have to line-item veto the entire PEI Plan. PEI is very clearly spelled out in the regulations, we didn't write them. It was approved by the voters.

Chairperson Mantas: Question for Sherry, if we take the path that Commissioner Kahler was recommending, slightly different from what he's presenting, can we go back and look at the qualification of the contractors that are involved in this process and evaluate them for their ability to provide the services that they are contracted for, after the fact.

MHSA Project Manager: You have 2 pieces, CSS and PEI. The blue handout is 24 pages of program and individual outcomes, if these programs meets these indicators or exceed them, their contract would be renewed. We made it very clear in PEI, if they don't perform according to these criteria, their contract will not be renewed. For CSS, they have a service work plan, with defined criteria to perform. What we can do is if you want to revisit all these criteria, we're happy to do that. And we can do the same thing with CSS, but you're going to have to give up more information on CSS.

Chairperson Mantas: Instead of the line-item veto, I recommend we revisit the performance contracts and make recommendations as a Commission if we believe that those contractors don't have the capabilities to deliver on the contract. We need to either add criteria or make recommendation that they be removed from the program.

Commissioner McKindley-Alvarez: Without us being knowledgeable about the criteria. I do not agree about Rainbow Coalition (Center) or other preventative strategies, so we would need to be informed as a Commission

Chairperson Mantas: Dave, would that be appropriate?

Commissioner Kahler: Yes.

8. **CLOSE PUBLIC HEARING**

- **ACTION: Motion made to close the public hearing at 6:30 pm (M-Pereyra/S-McKindley-Alvarez/ P- Unanimous, 6-0, Kahler, Mantas, McKindley-Alvarez, Overby, Pasquini, Pereyra)**

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 72 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours.

Contra Costa Mental Health Commission
Public Hearing-Capital Facilities Project Proposal
4/5/10
Minutes – Draft

1. CALL TO ORDER/INTRODUCTIONS

Commissioners Present:
Dave Kahler, District IV
Peter Mantas, District III, Chair
Carole McKindley-Alvarez, District I
Floyd Overby, MD, District II
Annis Pereyra, District II
Teresa Pasquini, District I, Vice Chair

Attendees:
Brenda Crawford, MHCC
Helen Geddes
Tom Gilbert, Shelter, Inc.
Ralph Hoffmann, NAMI
Marianna Moore, Human Services Alliance
Connie Steers, MHCC
Janet Wilson, MHCC

Commissioners Absent:
Colette O'Keeffe, District IV
Anne Reed, District II-Excused
Supv. Gayle Uilkema, Dist. II
Sam Yoshioka, District IV

Staff:
Donna Wigand, MHA
Suzanne Tavano, MHA
Sherry Bradley, MHA
Vern Wallace, MHA
Susan Medlin, MHA
Cindy Downing, MHA

Sherry Bradley had the interpreters from IEC introduce themselves: Thuy Trinh-Vietnamese, Marcela Morales-Spanish, and Barry Barlow-American Sign Language Spanish interpreter. If no one identifies or arrives to use their services within the first 10 minutes, they are free to leave.

Introductions were made around the room.

Chairperson Mantas opened the public hearing at 7:10pm

2. OPENING COMMENTS BY MENTAL HEALTH COMMISSION (MHC) CHAIR

3. MHSA DRAFT - CAPITAL FACILITIES PROJECT PROPOSAL by MHSA Program Manager Sherry Bradley

(PowerPoint presentation handout at the end of minutes)

She presented an overview on what the State Department of Mental Health (DMH) allows MHS Capital Facilities funds to be used for and how Contra Costa County (CCC) has proposed to allocate those funds. The DMH Information Notice 08/09 is the source document for both Capital Facilities and Technology funding. She reviewed Allowable expenditures for Renovation and examples of Allowed costs; she also presented examples of Costs Not Allowed.

The Capital Facility/Technology Component Proposal was approved 2/09 by State DMH, which functioned as a letter of intent showing CCC planned to use some funds for capital facilities and some for technology. The approved proposal included "new construction on property adjacent to CCRMC in the form of freestanding multi program mental health center with a continuum of services that will

provide a comprehensive recovery focused setting and a rapid response at entry including immediate mental health care which would lead to less restrictive levels of care more quickly".

The Component Proposal also said CCC would attempt to close gaps in the traditional medical model hospital based psychiatric unit by providing a continuum from restrictive to less and less restrictive settings and the location is on a frequently used public transportation line. The campus would serve adults, children and transition age Full Service Partners, older adults and other mental health consumers. The location was chosen because multiple programs could be sited there, including a more restrictive PHF if the County chose to build one, but the idea was to do less and less restrictive setting.

The proposed Capital Facilities project being reviewed tonight would propose a mental health Assessment and Recovery Center (MHARC) at County-owned 20 Allen St. It would be 6,000 sq. ft. and mixed use on demand. It would include business and operations support needed to support the new facility: parking spaces, medical records, dietary, housekeeping and a staff lounge.

Services provided at the MHARC would include voluntary urgent mental health care up to 16 hours per day for all ages and for discrete involuntary children's mental health care services. (MHSA funding is not being sought for the involuntary children's mental health portion of the site as the County would need to provide funding because it is a restrictive setting). It would also include an assessment center with a separate waiting room and entrance for children youth and separate entrances for adults and older adults.

Chair Mantas asked specifically what parts of the Project Proposal are not covered by MHSA funds. Sherry Bradley said MHSA funds cannot be used for the restrictive part of the children's involuntary setting. The County would have to fund it. Chair Mantas asked if there was knowledge of the level of BOS interest in funding the project. Suzanne Tavano said there was interest and it would not be completely at County sponsored program as there would be some revenue since most of the youth coming in on 5150 holds are Medi-Cal eligible.

Any deviations from the approved Component Proposal to the Project Proposal must be explained to State DMH. The deviation is the recommended change in funding distribution between Capital Facilities and Technology needs at the request of stakeholders to $4 million for Capital Facilities construction and $6.2 million for Technology Needs. State DMH says as long as the stakeholders agree to the deviation, CCC has met the requirement. Stakeholders were also concerned about the sustainability of a larger scale mental health facility as discussed in the earlier Component Proposal.

The Project Proposal is consistent with the five fundamental concepts inherent in MHSA.

4. PUBLIC COMMENT ON PLAN

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.

Ralph Hoffman: Would very much like to recommend for consideration as a location that is very transportation-friendly, the new Pleasant Hill Transit Village, at Pleasant Hill BART. There are about a dozen buses that serve that area as well and there will both commercial and residential

buildings that are going to be opening this spring in one big complex, both for purchase and lease. I understand this (funding) is for purchase only. Route 19 serves Concord John Muir, Route 18 serves CCRMC, Route 15 serves MHCC in Concord; it would be a very good location for a number reasons. It would be new construction so it would in very good condition, for earthquakes and there are Section 8 housing requirements in transit villages. Down the road, there are transit villages planned for Walnut Creek and Concord. You may be particularly interested in Concord, but they both have about the same number of buses serving those transit villages. These 3 locations we have planned for Transit Villages are designed because they are extremely transit accessible by all kinds of people.

Chairperson Mantas: As a point of clarification, the location is not up for debate, right? It's 20 Allen. There's no other provision to look at any other location outside of that.

MHSA Program Manager: Correct, because the county owns the property.

Ralph Hoffman: I'm mainly talking about how this is a 3-year project and this may be getting more funding down the road?

MHSA Program Manager: No, it's allocated for a 10 year period.

Janet Wilson: I am the Director for Patient's Rights for Contra Costa with Mental Health Consumer Concerns, and I came and stayed to speak in support of a Crisis Residential Facility (CRF), which was under consideration but now is not, due to the ARC. I think I may have a sense of why, because of all the accessibility of the Assessment and Recovery Center (ARC) maybe taking more space for Children, Adults and Older Adults. Still, I really wanted to put it out there how important a transitional crisis residential service would be to our county. We only have one, Neireka, it's over used, it has limited capacity. It would just be so important to the continuum of care in the County, for those wishing and willing to avoid acute hospitalization and everything that that means from seclusion and restraint to forced medication to everything that an involuntary hold means, for those wishing to avoid that, and able to avoid that, when outpatient care isn't sufficient. I want to bring attention to an article put out by the California Mental Health Planning Council on crisis residential programs. It was put out by the Adult System of Care Subcommittee of Crisis Residential Study report, it's a 7 page documents, but I wanted to read the ending paragraph, "Recovery, resilience, wellness and community have always been the cornerstones of the crisis residential program model and they are entirely congruent with federal and state mandate for community based mental health services. The economy and effectiveness they represent makes the need to mainstream them in the community as an essential priority for every County Mental Health Department startling the two worlds of human needs and fiscal constraints. Finally, Crisis programs are a time-tested, yet long under-utilized model, whose time has come."

Based on last week's Kaizen study, which took time and motion study of the Emergency Department 5150s and Crisis Stabilization Unit, one of the problems noted was the whole system is under-resourced, "the care of patients presenting to CCRMC for behavioral health needs is provided in a complex, sometimes disorganized, and under-resourced community environment". This would really be an important aspect of the continuum of care, if only it would not be left behind, if only there were not space considerations. Lastly, I do understand the need for the money for the technology. I really do understand that, for the needs of the Mental Health Division to do its Medicare and Medi-Cal billing, but I wish that the Crisis Residential would not be left behind. It'd be an important aspect of the continuum of care. Wish the CRF would not be left behind.

Brenda Crawford: I don't really need to say much more, since Janet so eloquently stated the need for a Crisis Residential, and I am so proud to be her co-worker. There's just a need. There's a need for alternative services in the County. We are not talking as though there isn't a need for an

electronic health record; we all know the benefits of that and we all know the benefits of upgrading a IT system, but for mental health consumers not to have choice between involuntary commitment and a place to go that would allow them the freedom that is recovery-based, in a county that is known for its creativity and courage, I can't fathom why that was taken off the table. I personally intend to go to Phoenix to experience it myself, in real time. I'm trying to work out the details of having them sort of admit me so I would know. I also know from an intellectual and heart level, that we need to create more opportunities for our consumers than we currently have.

Helen Geddes: I wanted to piggy back on the Crisis Stabilization Unit that Brenda brought up, I think it's something near and dear to my heart, having alternatives to hospitalization in Contra Costa is something that I'd like to see more of.

5. **CLOSE PUBLIC COMMENT ON PLAN**

6. **MHC COMMENT ON THE PLAN**

Commissioner Pereyra: I was very, very surprised when I went back and read the documentation, because I was involved in the split of IT and Capital Facilities funds. We were assured, even at that meeting with the CFO before the Board of Supervisors, that the funding was still going to be available for the CRF, that if the split of changed, so that more funds went into the IT component, which got an additional 4 million dollars, that the Pavilion Project, and Donna has now told me to not call it a 'pavilion', but that is what they referred to it all along, they assured us the Crisis Residential was still part of the package. Now in reading this, it says *if* the CRF is approved by the Health Services and the Board of Supervisors, and I almost feel like we got snookered, because we thought, all the people who were participating in the Capital Facilities and IT, that we were getting the Crisis Residential, that the only thing that had dropped off was the Psychiatric Health Pavilion. Yet, at the same meeting, before the Health and Human Services (Committee), I did hear Donna Wigand say that the Psychiatric Health Pavilion was back on the back burner, which means that they are still considering the PFH and quite frankly, if it ends up that we lose the CRF and end up with a PHF, I'm going to be ballistic, because it was not what we were told. We were told that if the Mental Health Director and if the County Administrator's Office has stated that this is the way it's going to be that we had to trust them that they would keep the CRF as a part of the package.

MHSA Program Manager: I want to give you some clarification. I actually tried to clarify this when Brenda Crawford brought this up at CPAW, and I said the 16-bed CRF is not off the table. I tried to say it then, and I'm going to repeat it again. I know that it is on the table. The reason that the plan was written the way it was is because any Capital Facilities construction has to be approved by the Board of Supervisors. That's why we were told we had to say 'if', because we don't have a crystal ball, we don't know what the Board of Supervisors will do. So everything that we do around Capital Facilities is pending whatever the Board of Supervisors wants to do, even requesting this money, they still have to approve the Capital Facility. That's all I have to say, the CRF is not off the table. Suzanne Tavano probably knows more about it, since I haven't been going to those meetings.

MH Deputy Director: I don't know anything more about it.

Chairperson Mantas: If we can refrain from this rebuttal, we'll go ahead and hear more Commissioner comments and come back.

Vice Chair Pasquini: Is there a quick clarification that you'd like to make, Suzanne?

MH Deputy Director: It wasn't a rebuttal actually. As you all know, I very much supported Crisis Residential and I don't think it hurts to advocate for it. We need it.

Vice Chair Pasquini: My understanding was that it wasn't in the plan, and so I understand Commissioner Pereyra's frustration. We sat in so many meetings and tried to work through it all, so I won't be recommending the ARC over the CRF. And Janet Wilson spoke very well of the California Mental Health Planning Council document that came out just last week, and actually, I'm not sure that you referred to the peer-run services, that they are emphasizing peer-run crisis residential programs. Based on our experience last week at Regional (CCRMC) and being embedded in the CSU (Crisis Stabilization Unit) and watching the number of hours that our consumers are waiting for beds, and whether they are in-patient beds or transitional beds. We don't need to have consumers waiting in a Crisis Stabilization Unit longer than necessary, when we have the ability to offer an alternative. I absolutely support everything that Janet said, and definitely would recommend the CRF over the ARC, if we have to prioritize. If we get one or the other, that would be my recommendation.

Commissioner Pereyra: I did notice that in paperwork that we got, that it is stated that $2 million/yr out of CSS would go to repair and maintenance of the facility, and then another $500K for program management. Is there that much wiggle room in CSS that you are going to be able to come up with 2 million dollars a year? Is it going to mean that there's less funding available?

MHSA Program Manager: If an individual is a Full Service Partner (FSP) and they are going to use this facility, this facility has to support MHSA supported programs and individuals like a FSP, whether a child, TAY, or Adult, that operating expense has to be covered out of CSS funds, so up to 2 million has been set aside for that purpose.

Commissioner Pereyra: It specifically stated that 2 million per year would be used out of CSS.

MHSA Program Manager: You were looking at the Component Proposal part of the package, which was included. When we did the Component Proposal that was a part of it. It was part of the Component Proposal, occurred 14 months ago, and had to be provided in this Plan. The Plan is updated; everything is included on the budget page.

MHSA Program Manager: Just so you all know, the recommendation from the stakeholders to do both the Mental Health Assessment and Recovery Center (ARC) and the Crisis Residential Facility (CRF) did go to Health Services. And my understanding is that a Board Order will be drawn, and it'll be up to the Board of Supervisors to make that decision about how that gets funded. But they do know and are very aware that there is strong support for a CRF. As soon as we know that the Board Order is ready, we will let you know. It's supposed to be coming up very soon; we actually thought it would happen before this public hearing.

Commissioner Overby: It's going to cost $600,000 for an architect to design a 6000 sq foot building, and $400,000 for landscaping. I'm wondering if these architectural fees include some extension later, for adding another unit or something? Isn't that out of portion?

MHSA Program Manager: We requested $200,000 in pre-development because through the architect, we also have to do the local environmental. I can't remember the term for it, but a lot of it is picked up by the architect and contracted through the architect. They have to get soil engineering and do assessment before building.

Commissioner Overby: Are they going to be tearing down the existing building and doing some landscaping?

MHSA Program Manager: I would think they would have to tear down the existing building eventually. If you see the property right now, there's parking lot, there's a building off to one side up the hill. So whether the existing building needs to be demolished for this construction has to be determined; that's not included in this.

Vice Chair Pasquini: What the Commission may want to know and I believe I'm correct is that I believe that the 20 Allen Project was part of the Hospital Master plan for hospital. I believe there were plans to purchase that property, initially that plan included the Psychiatric Pavilion.

MH Deputy Director: No, it's not a part of Contra Costa Regional Medical Center's Master Plan, but when the property was being assessed, they did all of the surveys, etc., and the property is large enough to hold all 3 of the original projects that were discussed: the PFH, the ARC and the CRF. This would be apart from the hospital campus.

Vice Chair Pasquini: The parking situation involved with 20 Allen is linked with the Master Plan in some way. There are also trees coming down too. There's a little bit of scuttlebutt going on about the trees on CCRMC's campus.

Commissioner McKindley-Alvarez: What was the purpose of the Mental Health ARC – the Assessment Recovery Center for children and youth? We have assessments that happen for children and youth in community, through contracted services? What was the thinking behind having this particular site be an assessment center for children and youth?

Child & Adolescent Program Chief: There is no 5150 Children's receiving center in the county. This is something, that in working on our continuum of care over the last 30 years, we have never had the ability to really assess and hopefully be able to hold kids for 23 hours and avoid hospitalization with work from our Mobile Response Team (MRT), or really adequately do a kid's assessment. This would be a first for this County. Currently, we have a mobile response team, part of the thinking behind this, is to really have a collaborative program with the Mobile Response Team sitting there, so that when families come in with their youngster, they are not having to necessarily look at hospitalization. We can send them home with MRT. The other piece is that we have situations where kids have had to spend lengthy periods of time sitting at CSU, in an environment that really isn't appropriate for them. Our population has grown and we have a lot more kids going through our current CSU than we had even 5 years ago.

Commissioner McKindley-Alvarez: So it's on the table that we have to pick between the two of these? I understand that this is how it's being presented in the Plan, and that there's some dialogue about us being able to have the CRF, and I'm a little skeptical when hearing that there's a plan that is coming down somewhere for a CRF, as opposed to that is something that is actually being articulated and presented to us today. Both populations really need the services, without a doubt. Children sitting within the CSU is just unthinkable, it's scary and more traumatizing than whatever they may be experiencing in that moment, but not having different level of care for the adults is also unthinkable, having one place to go , which is a place we'll have to visit because there have been complaints about one place. It's just not acceptable. I'm concerned that we're being presented with a plan that is just one thing, and that we're not addressing both issues at this time.

MHSA Program Manager: The problem is that the funding only can do so much. We can include things in the plan, but the State is only going approve funding for what we recommend.

Vice Chair Pasquini: Having been on the unit last week, with Janet Wilson and Dave Kahler, we observed adolescents and it's absolutely not ideal. However they were two adolescents on the unit when we were there and they are definitely segregated.

Brenda Crawford: I agree with Commissioner McKindley-Alvarez. I trust that the CRF is not a closed conversation, but to have it not be a part of the ongoing conversation in a way the ARC has now become a part of it, the Adult and Children and the Older Adult, so the CRF is off in the corner somewhere, but we know that it's not a done deal. If that is the case, and I have no reason not to believe that, that we come out and have it as a priority. That we look at that in the same light that we are looking at the Assessment Recovery Center.

Chairperson Mantas: Vern, on CRF, I'm hearing the provision for a 72 hour hold is there – is there any provision for extended hold, for a 5150, if an adolescent needs to stay longer?

Child & Adolescent Program Chief: Kid would come though the unit and go to a contract hospital. There will not be an inpatient unit for children. We would basically have the ability to hold

them for 23 hours, but in counties that have this type program, such as Alameda County, they are able to divert about 64% of their kids from hospitalization by having Mobile Response there with the County clinicians, and transitioning them back home with support. So no, we're not proposing an inpatient unit.

Chairperson Mantas: So if a private hospital declines to take an adolescent for inpatient services, what happens to the adolescent, in the proposed plan?

Child & Adolescent Program Chief: The same type of situation would exist in terms of having to find an open bed in a contract hospital.

Chairperson Mantas: So in other words, still haven't solved that problem?

Child & Adolescent Program Chief: We haven't solved that problem, but we will certainly solve the problem of having this many children go to hospitalization, or be handled in a unit where no one has children's experience and there isn't an attending psychiatrist that has children's certification. So that problem will be resolved.

Vice Chair Pasquini: How can you hold someone 23 hours at a facility that's open 16 hours?

MH Deputy Director: The reality is if we are receiving children on 5150 and there is a child there, that there would have to be care provided for the 23 hours. We would have provisions for that.

Child & Adolescent Program Chief: We don't get into situations that often where we have to hold children 23 hours.

Commissioner McKindley-Alvarez: So you would have provisions in place?

Child & Adolescent Program Chief: Yes

Chairperson Mantas: Why wasn't that challenging issue addressed to this process? Is it because MHSA funding doesn't support it? Why would we not solve this since we're on the playing field?

MH Deputy Director: For acute inpatient care, that's considered involuntary, it's not covered under MHSA unless the consumer is enrolled in a Full Service Partnership and then there is an exception for 30 days, but it's considered restrictive care. That's why you can't use it for a hospital; that's why when the whole discussion was going on about PHF, which would have been locked, MHSA money couldn't be used for that either.

Chairperson Mantas: You mentioned that the CRF is not funded by MHSA

MHSA Program Manager: Right, that's why it's not included in this Project Proposal. It's referenced and mentioned, however the recommendation that was made by the stakeholders, and there were several recommendations, that was forwarded by Donna Wigand to the Health Services Department, to Dr. Walker and Mr. Godley, to be included. They are aware that's the recommendation, to include the Crisis Residential Facility and include 16 beds.

Chairperson Mantas: Is there a price tag to the CRF?

MHSA Program Manager: When proposal was made to have this multi-program campus that had a CRF, and the PHF and ARC, the entire campus cost was around $23 million dollars. So you could back those numbers out, the ARC is $4 million, so $19 million for the CRF, but that was for both the PHF and the CRF.

MH Deputy Director: The PHF would have been the most expensive of the facilities because it'd be 24 hour, acute care.

MHSA Program Manager: So even if you split it, and you guessed that $11 million was the PHF and $8 Million would be the CRF, approximately. I'm not sure, I've never gotten information about what a CRF would cost.

Chairperson Mantas: If there's a proposal going to the Board of Supervisors, how can they vote on this thing without having a price tag?

MHSA Program Manager: Peter, I'm sorry, I'm not involved in those discussions, it has nothing to do with the MHSA so I can't answer your question.

Vice Chair Pasquini: So this is seed money for a project, is that what this basically is?

MHSA Program Manager: This would only pay for one mental health program on that campus
Commissioner Pereyra: And only part of that one program, right?
MHSA Program Manager: Because the involuntary part cannot be paid for by MHSA funds.
Brenda Crawford: So to Peter's point, how can the Board of Supervisors make decisions on services when they have so little information about the price tag of a Crisis Residential Facility and they have, to my knowledge, I don't even know if they have any information about the impact, or knowledge about the programs in similar states. How can they make the decision in the absence of all of that information?
Chairperson Mantas: Let me just make a quick statement as to why I'm asking this. I'm trying to form an opinion, a recommendation and a personal decision. Without the CRF, I mean, this is nice but, it's virtually useless, as far as I'm concerned.
Commissioner Pereyra: Can I interject another comment, because perhaps Commissioner Overby has been involved in this before, but having served in health care my entire career, to have a project get built and have the ARC up and running and then to be adding on the CRF to it at a later date, is enormously disruptive. And why, if they were going to do it, and they were committed doing it, why are they not doing the whole building at one time instead of doing it piece meal? It's very problematic.
MH Deputy Director: We've not been in the continuing conversations, once everything started getting so complicated, but the architect that was involved in assessing the property and coming up with a basic proposal of what 3 buildings could be located there, because the whole discussion was that it shouldn't be a big block of a building, that if there were a PHF, it should be separate and distinct. The ARC, should be separate and distinct and the CRF, since it should be home-like, it should be a house, not a concrete building. So they came up with architectural plans for each and my guess is that they were able to break out the cost of the 3 different facilities and that's what they are going off of. So it was costed out as a full project but with the different components.
MHSA Program Manager: And the numbers that are in the package were provided by Health Services Finance, so I'm sure that they had all that information.
Chairperson Mantas: This Commission is responsible for review of all of this stuff, not just MHSA. And we're providing an opinion with less than perfect data. How can we do that? This is the frustrating part of all of this. We have moving targets. I am frustrated with this and I find that this project without the CRF, as I said before, I feel it's useless. Maybe I'm wrong.
Vice Chair Pasquini: I totally disagree that it's useless.
Chairperson Mantas: So what are getting that we don't have now?
Vice Chair Pasquini: We're getting discrete services for Children and Older Adult that we don't have now. We can debate whether that's priority or not. I was willing to continue to discuss that, however at the Family and Human Services Committee, it was clearly indicated that they (the Board) weren't interested in any more dialogue. The back conversation ended and the Board Order is going forward, so now we have a choice of whether or not to support the current suggestion or not and I personally, I would like to send a statement that we absolutely do not support. I don't have enough information to support an ARC over a CRF. I didn't have it then and I don't have it now.
Chairperson Mantas: I'm not sure that we necessarily need to oppose the ARC, because the ARC is getting funds from MHSA.
Vice Chair Pasquini: But the CRF could too.
MHSA Program Manager: Yes, part of the funds, you could only get $4 million. Then you'd still be right where you are right now which is that you don't know what you don't know, because you still don't know if they (the Board of Supervisors) are going to cover the rest.

Chairperson Mantas: And we don't know how much that is, so we don't know if we would be unrealistic for asking. For me personally, I would say that I'm in favor of the proposal with the provision that the CRF is part of the plan. If it's not, then we need to revisit.

MHSA Program Manager: You can certainly recommend that, absolutely and then your message goes forward.

Chairperson Mantas: I'm asking for your thoughts.

Vice Chair Pasquini: I'm still opposed to the process that took place. I don't like the way it ended up. I don't like the conclusion and so I would have preferred to have additional answers given. Especially since I was (part of the value-streaming event at CSU), and I know that people can get annoyed that I continue to bring it up, but for me it was very valuable to scientifically sit and be on the Unit and watch the process, rather than have numbers that seem to change. I don't have facts. I don't have enough scientific evidence to support this.

Commissioner Overby: I don't think it's ideal, but I think anytime we get something for mental health we should take advantage of it, if there is money available to do so.

Commissioner Pereyra: You have to convince Commissioner Kahler of that, with all the PEI and Innovation money.

Commissioner Kahler: Me? I'm the one who voted September 3rd for the $22 million project, and right there, this Commission torpedoed it. And now we are scrambling around the edges of what's left.

Vice chair Pasquini: Can we take a motion?

Chairperson Mantas: I don't know what motion to take. I offered up my thoughts. What does everyone else want?

Commissioner Kahler: I agree with your thoughts

Chairperson Mantas: It didn't sound like it a minute ago.

Commissioner Pereyra: So you're putting a 'if and only if' clause in any motion, that the only way that we could support it, is if and only if the CRF is included in the package?

Chairperson Mantas: Yes, that's my current motion

Commissioner Kahler: How do you feel? Do you support that? Let's get a consensus here and go home.

Chairperson Mantas: Carole, any thought?

Commissioner McKindley-Alvarez: No, I'm conflicted. I'm saddened that we're at this crossroads. Again, I believe that the children need the service and if it was just us talking about the children getting the service and it wasn't then negating another really important service, it would be easier.

Chairperson Mantas: I feel exactly the same way. The only reason that I even made the statement that I feel that this plan is useless is because I know that with proper engineering, the CSU could probably handle some of this, as they are doing now. I have faith in that process now. The Lean process I believe to actually development something that can be a lot more than what we have now. However, I believe that if we don't go forward and say to the Board of Supervisors that, here's how we feel, we feel so strongly about the CRF, they may not put so much time and attention to it. That's my feeling.

Vice Chair Pasquini: I make a motion that we support a CRF over an ARC.

Commissioner Kahler: Second

Chairperson Mantas: Be careful with the way that we start motions here. Allow me the opportunity to acknowledge that you're going to be making a motion. (To Vice Chair Pasquini) Can you frame it? I don't understand what you're trying to say. Are you opposed?

Vice Chair Pasquini: I'm opposed the priority being the ARC. And I'm making a motion that the Commission make a recommendation to the Board that a peer-driven, peer-run, CRF be given priority at 20 Allen.

Chairperson Mantas: (To Vice Chair Pasquini) And you're opposing the plan?

Vice chair Pasquini: That's what I just said.

MH Deputy Director: I am certainly a supporter of having a CRF, but I also am a supporter of the ARC because in addition to the specialized services for children and adolescents for 5150 care that Vern Wallace was talking about, we do not urgent care availability in the county now, for adults, children and adolescents after hours. The only thing (after hours) is if someone is going to the CSU; the CSU shouldn't be for people that don't need to be hospitalized. There should be a place where people can go where it's 5, 6, 7, 8, 9, 10 o'clock at night, if they're having crisis, to go to. CSU can only claim Crisis Stabilization services; they can't claim individual treatment, medication services, crisis intervention, etc. I wouldn't want the value of the ARC to be overlooked. Also in terms of medication support services, part of the thinking was, that there is such a long wait to get into see a psychiatrist following a hospital and IMD discharge, at the ARC, there would be able be short term psychiatric medication management services also.

Brenda Crawford: Tom (Gilbert, Shelter Inc) and I were just talking about a facility that he is aware of that he and Victor Montoya (Adult Services Program Chief) could consider for shared housing. So I would just ask that we be open to the possibility of a CRF in this County, that the County embrace that idea and that there are ways of doing that. Tom Gilbert just talked about a property where we could do that. I know we're at a crossroads, and I too am at a crossroads. I don't want children to have to go into the normal unit and have to be subjected that additional trauma. I also have a feeling for older adults, I know what isolation does to older adults and I know how underserved that population is. I also know that adults in this county need an alternative to what we currently have.

Commissioner Pereyra: Sherry, can you clarify for them about housing money?

Tom Gilbert: We don't want to use housing money. This is a 9 bedroom house on 2 acres in Concord for under a million dollars.

Chairperson Mantas: Sherry, is there County money that's going into the ARC?

MHSA Program Manager: Yes.

Chairperson Mantas: How much, approximately?

MHSA Program Manager: I don't know. I'm sorry, I wasn't told what that amount would be, but I was told that the facility would be constructed, the amount would have to be prorated and then that has to be reported to the state in another process.

Chairperson Mantas: If there isn't a significant amount of money from the County that needs to be invested in the ARC, then it would be foolish of us to make the recommendation that we don't want the ARC. But if it's significant and would inhibit us from getting funds for the CRF, then we would have to make a decision on what we feel is more appropriate, the highest need. That's my feeling right now, so how can we make that decision

Commissioner Pereyra: Do we have enough information to make a decision or do we need to delay this so that we can get more information that can provide us with the answers before we're forced to make a decision.

MHSA Program Manager: I have to give you one more clarification, I was supposed to do this at the start, but the meeting got to be so long, but I need to say this, because I don't want this to be something that I did not say. Dorothy Sansoe from the CAO's office, recommended that we make an announcement at the beginning of the public hearing that we are not required to have this public hearing per the State Department of Mental Health guidelines, because the public hearing actually occurred during the Component Proposal presentation in February of 2009,

actually it was January of 2009. Because of that, the State Department of Mental Health is going to look at this, and even if you say you support it or you don't support it or whatever, I just need you to know that there is that disclaimer that we need to say to them, while a public hearing was not required, the Mental Health Commission held one. I'm just telling you that, so that whatever you decide, I will have to put that in there.

Chairperson Mantas: I'm glad that you made that statement and as a citizen of this County, I will go to the OAC and I will make my comments known there and I will also put a motion in a future meeting in this Commission to basically challenge those decisions because the law is clear. We have made a significant change to the presentation that we made before the prior public hearing. We don't even have numbers to look at now. If this is just a game and this means nothing, then we can go ahead and adjourn the meeting.

MHSA Program Manager: It's your choice. It's not a game.

Chairperson Mantas: Commissioners, what would you like to do?

Commissioner Overby: Could we table it for discussion at another time?

Chairperson Mantas: We could, but I don't know what good it's going to do.

Commissioner Overby: You say you don't have the information that's necessary to make a vote.

Chairperson Mantas: Or we can go ahead with a motion that Teresa was proposing a little while ago. I don't want to go through a motion and we end up wasting time going back and forth on this stuff. What do you feel about Teresa's comments? No Comment. What do you feel about my position that we approve it with the condition that the CRF is a part of the plan?

Commissioner Overby: I think that's logical

Chairperson Mantas: So Dave?

Commissioner Kahler: I'd be more inclined to agree with Floyd and table it and get more information.

Chairperson Mantas: Carole?

Commissioner McKindley-Alvarez: I don't know

Chairperson Mantas: Teresa

Vice Chair Pasquini: I already said initially that I opposed the way this process has been, almost from the beginning and process-wise, I let go of this on whatever day that was that we sat at this table with Supervisors Uilkema and Glover up there, telling us that, you know. I let go of this, I've moved on. I'm aware of the DMH guidelines but I'm also appreciative of Peter's desire to have this conversation again because there was not satisfaction after months and months and months of hard Commissioner work. I am ready to go home and I'm done. So if we're not going to do anything, I'm ready to go. I'm going to walk out.

MH Deputy Director: If there was some way that we could figure out to get both, I think that would be the best strategy for the consumers of this county. I'm concerned that if this falls apart here, then we're back to losing all possibilities rather than using some negotiating power to get both.

Vice Chair Pasquini: Then I would really recommend that there be effort made to bring the Commissioners back in, because there was a falling off. I was present. I have given hours and hours and hours and I'm not willing to give anymore hours to chit chat about something that I'm going to be told is a done deal.

Chairperson Mantas: Here's my responsibility. My responsibly under Welfare and Institution Code 5848…Teresa, I'm sorry you're uncomfortable with this.

Vice chair Pasquini: I am.

Chairperson Mantas: '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..' so on. I'm doing my job. This what the WIC communicates to me.

MHSA Program Manager: This is not a draft plan or an annual update.

Chairperson Mantas: It's an update.

MHSA Program Manager: It's not considered that by the State Department of Mental Health.
Chairperson Mantas: So what are we calling it?
MHSA Program Manager: It's a project proposal. I'm sorry. It's not my terminology. I don't write the regulations.
Chairperson Mantas: Terminology continues to change. What was it called back then?
MHSA Program Manager: It was called the Component Proposal.
Brenda Crawford: So Peter, if your motion about seeing if we can have it all, and if there are ways we can have it all for less amount of money, if there are way that we can bring ideas together. I mean, Tom and I were just talking about a piece of property and it's not housing money and it's significantly less money than what is being proposed right now. So all I'm asking is that we be creative because we know that there's a need for a CRF here. And it doesn't have to be done in the context of this process, if we can be open to talking about different ways of getting these services. That's what we need, we need the services. If there's a way of doing that without holding up this process, I think that's the way we should go. It doesn't serve consumers for us to send this back. Whether we get the ARC, or it's children consumers or adults consumers, not following through on this process doesn't serve consumers. It serves consumers if we can be creative about how to meet the needs of all target groups in this area.
Commissioner Overby: Do we have a quorum?
Chairperson Mantas: We do.
Commissioner McKindley-Alvarez: We do.
Chairperson Mantas: How do we want to approach this?
Commissioner McKindley-Alvarez: What's your motion again? Or what motion needs to come from someone else?
Chairperson Mantas: My preference is that we approve the plan with the caveat that the CRF is a part of the final plan submitted to the OAC, to the State. Which means that the Board of Supervisors, if they wanted to follow the recommendation, would have to have the CRF funding along with the ARC.
Commissioner McKindley-Alvarez: Within the MHSA money? Or as a part of the plan?
Chairperson Mantas: MHSA money and as a part of the plan. So that's one option, the other is table or the other one is oppose the current plan and go with the CRF rather than the ARC, which is what Vice Chair Pasquini is recommending.
Vice Chair Pasquini: You can frame a motion requiring something when there isn't funding there. There is not enough funding.
Chairperson Mantas: What I heard was that if the Board of Supervisors approves the funding for the CRF, it will become a part of the plan, correct?
Vice Chair Pasquini: (Sherry) has no financial information.
MHSA Program Manager: I cannot answer that question. I'm sorry. I don't have that information.
MH Deputy Director: I think that if we advocate together, we can probably get more out of the county than when we don't.
Vice Chair Pasquini: I agree.
Chairperson Mantas: (Suzanne) Do you have a recommendation?
MH Deputy Director: The ARC was seen as the starting point. I know that's how the County is looking at it. I don't think it is going to work to say scrap the ARC and do a CRF instead. I think there is negotiating power right now by saying both are needed.
Vice Chair Pasquini: That's been said for month. We need everything.
MH Deputy Director: At that last meeting that you referenced, Teresa, I think what happened was that there was strong advocacy for the children adolescent sector and the ARC. What would have

been nice is if at that same meeting, there would have been strong advocacy for the CRF and then both would have been a part of the package.

Vice chair Pasquini: We had already made a recommendation, Suzanne. And there had been a breaking down of discussions, if I recall. There was a recommendation coming forward from CATF but the Commission had also made a recommendation, our Capital Facilities workgroup had made a recommendation. Our recommendation at that point was overwritten.

Chairperson Mantas: This is the last comment and then we need to act.

Susan Medlin: On behalf of consumers, it'd be wonderful if we could come out as one force with advocates, consumers, family members at the Board of Supervisors meeting advocating for both and it was backed up by your recommendation. Or vice versa, and we'd be backing you up, to include both. It's an important priority that you have heard from consumers and family members that it's an important priority that we do both.

Commissioner McKindley-Alvarez: I'm going to move that we accept the proposal for the ARC only with the condition that we have a commitment from the county that the CRF is not just placed on the table but is acted on appropriately.

Chairperson Mantas: Any comments?

7. **DEVELOP LIST OF SUBSTANTIVE COMMENTS AND RECOMMENDATIONS TO THE COUNTY MENTAL HEALTH ADMINISTRATION (MHA) AND TO THE BOARD OF SUPERVISORS (BOS)**

   NOTE: The MHA does not have to follow the MHC's recommendations. However, the MHA must incorporate MHC recommendations as part of the adopted plan along with appropriate analysis.

   ACTION: Motion made to approve the Capital Facilities Project Proposal only with the condition that there is a commitment by the County that the Crisis Residential Facility is not just placed on the table but acted on appropriately, and on the minor conditions that substantive comments be brought up and included in the Plan by MHA. (M-McKindley-Alvarez/S-Pasquini/P-Unanimous, 6-0, Kahler, Mantas, McKindley-Alvarez, Overby, Pasquini, Pereyra)

8. **CLOSE PUBLIC HEARING**

   - **ACTION: Motion made to close the public hearing at 8:46pm (M-Overyby/S-Kahler/P-Unanimous, 6-0, Kahler, Mantas, McKindley-Alvarez, O'Keeffe, Overby, Pasquini, Pereyra)**

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 72 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours.

Contra Costa Mental Health Commission
Monthly Meeting
April 8, 2010
Minutes – Draft

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 (sp)
Leslie Rubman (sp)

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**

- **<u>ACTION:</u> 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)**

- **<u>ACTION:</u> 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)**

- **<u>ACTION:</u> 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?

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 (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 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 save, 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. 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 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 is the pressing need for another 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 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 public 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 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 previously.

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. Shouldn't something more 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 all their training and experience to. It is

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

File

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.

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(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.

5/13/10 MHC Meeting
Response to County Counsel's comments to Mental Health Commission's proposed Bylaws changes

Item 1 of Counsel's letter:
Workgroup agrees with County Counsel's recommendations.

Item 2 of Counsel's letter:
Workgroup does not agree with Counsel's recommendation. "SECTION 2. ROLES AND RESPONSIBILITY
As specified in the Welfare and Institutions Code Sections 5600 and 5800." The bylaws need to reference the sections of the W&I Code sections that contain the current statutory responsibility of the Mental Health Commission. Also keeping it this broad reference form allows for future expansion of the Commission's responsibility by the amendments to the Welfare and Institutions Code which will be made in these sections. This will eliminate the need to amend the Commission Bylaws as its responsibility expands. The perfect example is the addition of MHSA responsibilities added to section 5800 when Prop 63 passed.

Item 3 of Counsel's letter:
Workgroup agrees with Counsel's recommendation.

Item 4 of Counsel's letter:
Workgroup agrees with Counsel's recommendations.

Item 5 of Counsel's letter:
Workgroup agrees with Counsel's recommendation.

Item 6 of Counsel's letter:
Workgroup would like to retain adopted language to impose a term limit of four consecutive three-year appointments.

Item 7 of Counsel's letter:
Workgroup agrees with Counsel's recommendations.

Item 8 of Counsel's letter:
Workgroup agrees with Counsel's recommendations.

Item 9 of Counsel's letter:
Workgroup agrees with Counsel's recommendation.

Item 10 of Counsel's letter:
Workgroup does not agree with Counsel's recommendation. Due to the fact that the Mental Health Commission has traditionally not been fully staffed the Board of Supervisors approved the simple majority voting provision. The simple majority allows the Commission to be productive. If an absolute majority is needed it would create stalemates that would hinder the Commission's progress. We believe this to be detrimental to the Commission. The Bylaws amendment proposed by the Commission

with respect to the voting was only done to clarify voting requirements not change the intent. To provide explicit instructions for voting requirements Simple and Absolute Voting should remain intact as approved by the MHC.

Item 11 of Counsel's letter:
Workgroup agrees with Counsel's recommendation.

Item 12 of Counsel's letter:
Workgroup does not agree with Counsel's recommendation. Counsel cites Gov. Code, 54953 C as prohibiting secret ballots. However, Counsel does not talk to the 2003 clarification by the California Attorney General which states the following:

"C. Secret Ballots

Secret ballots are expressly prohibited by section 54953(c). This office has long disapproved secret ballot voting in open meetings and the casting of mail ballots. Thus, items under consideration which are not subject to a specific closed meeting exception must be conducted in a fully open forum. (68 Ops.Cal.Atty.Gen. 65 (1985).) One aspect of the public's right to scrutinize and participate in public hearings is their right to witness the decision-making process. If votes are secretly cast, the public is deprived of a portion of its right. (See also 59 Ops.Cal.Atty.Gen. 619, 621-622 (1976).) However, it is the view of this office that members of a body may cast their ballots either orally or in writing so long as the written ballots are marked and tallied in open session and the ballots are disclosable public records."

Based on this clarification which lives up to the spirit of the law, the workgroup recommends keeping its new approved language.

Item 13 of Counsel's letter:
Workgroup does not agree with Counsel's recommendation. The current Bylaws were approved by the Board of Supervisors in 2006 and have allowed the use of task forces. It should be noted that the Commission hasn't assembled a task force. However, the Commission wanted to have the option to assemble a task force as needed but would also like to offer the public which participate to have voting rights. It should be noted that the task force will only make recommendations to the full Mental Health Commission to act on its recommendation. Since the commission retains its statutory responsibility, authority and advisory responsibility to the BOS this should not be an issue. The only change proposed is giving the public voting rights.

Item 14 of Counsel's letter:
Workgroup does not agree with Counsel's recommendation. By statute the Welfare and Institution Code implies pseudo-supervisory responsibility of the Commission to the Board of Supervisors. The Workgroup recommends that the approval authority for the procedures be the Board of Supervisors.

Office of the County Counsel
651 Pine Street, 9th Floor
Martinez, CA 94553

Contra Costa County
Phone: (925) 335-1800
Fax: (925) 646-1078

Confidential
Attorney-Client Privileged Communication

Date: June 24, 2009

To: William H. Walker, Health Services Director
Attn: Donna M. Wigand, LCSW, Mental Health Director

From: Silvano Marchesi, County Counsel
By: Mary Ann McNett Mason, Deputy County Counsel M.A.M.

Re: Review of Proposed Changes to Mental Health Commission Bylaws

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We provide the following comments on the proposed revisions to the bylaws of the Mental Health Commission.

1. **Article II, Section 1. Authority.** The statutory references are incorrect and should not be included. The Bronzan-McCorquodale Act is not known as "Section 5604." That section, which is only one part of the Act, simply defines the parameters for the Commission. Welfare and Institutions Code section 5600 expressly provides that the Act "shall be known and cited as the Bronzan-McCorquodale Act." In addition, the reference to "the Mental Health Services Act Section 5800" is incorrect, and that section does not give any authority to the Mental Health Commission. Section 5800 provides that one article in the Welfare and Institutions Code "shall be known and cited as the Adult and Older Adult Mental Health System of Care Act." It is suggested that all of the proposed new language be deleted from the bylaws.

2. **Article II, Section 2. Roles and Responsibility.** It is suggested that the section be deleted. The new language does not correctly specify the laws which delineate the Commission's role. In addition, since the Commission's role is a matter of state statute, there is no need to address it in the bylaws. In general, bylaws should cover matters of operation and procedure only and should not attempt to paraphrase or cite statutes. Inaccurate legal references and summaries of statutes can easily confuse Commissioners and others who rely on the bylaws.

3. **Article III, Section 1. Membership, A.** It is suggested that the proposed revision be omitted as an unnecessary restatement of legal requirements.

4. **Article III, Section 1. Membership, B.** It is suggested that the proposed revision be modified to read:

"If at least twenty percent of the total commission membership are not Consumers and/or if at least twenty percent of the total commission membership are not Family Members, a commissioner for the underrepresented category may be selected from

any Supervisorial district, if there are no applicants from the impacted district."

In the second bullet, it is suggested that the bylaws refer to "State registered domestic partners" because this term has a recognized legal status with associated rights and responsibilities.

5. **Article III, Section 1. Membership, E.** This provision would prevent appointment of any person "who has a potential conflict of interest." This is more restrictive than state law. (W &I, Code, § 5604 (e).) Normally, a potential conflict of interest is not a basis on which a person is deemed ineligible to serve on a commission. Instead, the person with a conflict of interest must recuse himself from participation in the decision in which he has a conflict. This provision, and justification for its inclusion should be pointed out to the Board of Supervisors in the Board Order accompanying the proposed by-laws.

6. **Article III, Section 3. Terms.** The imposition of term limits is a significant change. This provision should be pointed out to the Board of Supervisors in the Board Order accompanying the proposed by-laws so that they can determine whether to impose term limits.

7. **Article III, Section 4. Vacancies, B and C.** The reference to moving outside the County limits is uncertain. Appointees may be from locations outside the County if a Supervisor desires. The reference to subsection H is uncertain. We could not find subsection H. Please revise or omit this reference. Mean E

8. **Article IV, Section 3. Quorum.** It is recommended that no amendment be made to this section. The new wording is unclear.

9. **Article IV, Section 6. Open Meetings.** The Commission, its standing committees, task forces, and work groups, must comply with all aspects of the Brown Act and the Better Government Ordinance, not simply the requirement that meetings be open to the public. To reflect this, it is suggested that the section be revised to read: "All meetings of the Commission and all meetings of the standing committees, task forces and work groups appointed by the Commission shall comply with the Brown Act and the County's Better Government Ordinance."

10. **Article IV, Section 7. Decisions and Actions of the Commission.** This section is inconsistent with the Board of Supervisors policy on advisory body decision making. Normally, the Board requires that advisory bodies act by majority vote of the total number of seats. Given that the Commission has a less restrictive quorum requirement than other bodies, it would be reasonable to require action by a majority vote of the total number of filled seats- akin to a decision by "an absolute majority" as defined in the proposed bylaw. It is suggested that the section be revised to provide that the Commission may take action only upon a majority vote of the total number of filled seats. References to "absolute" majority votes and "simple" majority votes should then be removed throughout the document.

If this recommended revision is not made, in the Board Order proposing adoption of the bylaws, you should point out the proposed number of votes necessary for Commission action and the justification for this variance from standard advisory body practice.

11. **Article V, Section 1. Nomination of Officers.** The final sentence of the proposed modification is unclear as to what steps must occur for a mid-term appointment. It is suggested that the final sentence be revised to read: "Should one of these positions become vacant during the term of office, nominations will be taken, nominees' consent to serve will be obtained, and nominees will be announced at the next regularly scheduled commission meeting." Once nominations are announced, then elections would proceed under Section 2, Election.

12. **Article V, Section 2. Election.** As written, it is not clear that the process for elections complies with the prohibition against the use of secret ballots. (Gov. Code, 54953 (c).) So that the process will be clear, the first two sentences of the second paragraph should be revised to read: "The election will be conducted publicly at the meeting. Each Commissioner will vote by submitting a signed ballot. At the meeting, votes will be counted and the vote of each Commissioner will be announced by the Membership/Nominating Committee and recorded in the minutes."

13. **Article V, Section 6. Task Forces, B.** This section provides that persons other than Commission members may serve on Commission task forces. Typically the Board of Supervisors requires that all subgroups created by advisory bodies consist only of advisory body members. (See Board of Supervisors Resolution 2002/377, § II.) In the Board Order proposing adoption of the bylaws, you should point out that the Commission would be permitted to form task forces that include members of the public and give a justification for this deviation from standard advisory body practice. Also, it is suggested that the bylaws place a limit on the number of members any task force can have. Otherwise, the task forces could become unwieldy and expensive to operate.

14. **Article VIII, Commission Policy and Procedure Manual.** The draft bylaws contain numerous references to this manual. It is suggested that the Mental Health Director carefully review this manual to ensure that it is limited to procedural matters that are within the Commission' purview as authorized by bylaws approved by the Board of Supervisors. The manual should not address anything beyond that.

MAM/am

cc: County Administrator
Attn: Dorothy Sansoe, Senior Deputy County Administrator

Revised Draft – with County Counsel's Recommended Changes 7-14-09
Final Draft Revisions -- Approved at Special Mental Health Commission Meeting 4/6/2009

Plain, black text = No changes in original text.
~~Red strikethroughs~~ = Proposed deletions of original text.
Bold, yellow highlighted = Proposed changes and/or additions to original text.

ARTICLE I
NAME OF ORGANIZATION

SECTION 1. NAME OF ORGANIZATION
The name of the organization shall be the "Contra Costa County Mental Health Commission."

ARTICLE II
GENERAL PROVISIONS

SECTION 1. AUTHORITY
The Contra Costa County Mental Health Commission ("Commission" hereinafter) was established by order of the Contra Costa County Board of Supervisors on June 22, 1993, pursuant to the Bronzan-McCorquodale Act, Stats. 1992, c. 1374 (AB. 14), ~~also known as the Welfare and Institutions Code Section 5604. Additional authorities were bestowed upon the Mental Health Commission by the Mental Health Services Act Section 5800.~~

~~SECTION 2. ROLES AND RESPONSIBILITY~~
~~As specified in the Welfare and Institutions Code Sections 5600 and 5800,~~
~~The Commission shall:~~
~~A. Review and evaluate the community's mental health needs, services, facilities, and special problems.~~
~~B. Review and County agreements entered into pursuant to Welfare & Institutions Code 5650.~~
~~C. Advise the Board of Supervisors and the Contra Costa County Mental Health Director as to any aspect of the local mental health program.~~
~~D. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.~~
~~E. Submit an Annual Report to the Board of Supervisors on the needs and performance of the County's mental health system.~~
~~F. Review and make recommendations on applicants for the appointment of Contra Costa County Director of Mental Health Services. The Commission shall be included in the selection process prior to the vote of the Board of Supervisors.~~
~~G. Review and comment on the County's performance outcome data and communicate its findings to the California Mental Health Planning Council.~~
~~H. Perform other duties as authorized by the Board of Supervisors.~~

~~As part of its duties set forth above, the Commission shall assess the impact of the realignment of services from the State to the County, on services delivered to clients and in the local community.~~

ARTICLE III
MEMBERSHIP

SECTION 1. MEMBERSHIP

The Commission shall consist of fifteen (15) members appointed by the Board of Supervisors, plus one member of the Board of Supervisors and an alternate assigned to be a representative to the Commission. Each member of the Board of Supervisors shall have three (3) members representing his or her district. The specific seat to be assigned to each nominee will be determined by the member of the Board of Supervisors making the nomination.

The following rules shall apply to membership of the Commission:

A. One (1) member of the Board of Supervisors shall be a member of the Commission, ~~as required by Welfare and Institutions Code Section 5604.~~ The Board of Supervisors shall also appoint one (1) Supervisor to serve as an alternate member.

B. Pursuant to the Welfare & Institutions Code Section 5604, fifty percent (50%) of the Commission membership "shall be consumers or parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services." ~~Membership is divided equally among the five (5) districts. However, should Consumer or Family Member commissioners fall below the twenty (20%) minimum per category or fifty percent (50%) total, as required by the Welfare & Institutions Code, applicants shall be considered from other districts, if available.~~ **If at least twenty percent of the total commission membership are not Consumers and/or if at least twenty percent of the total commission membership are not Family Members, a commissioner for the underrepresented category may be selected from any Supervisorial district, if there are no applicants from the impacted district.** On this Mental Health Commission, membership shall consist of:

- Five (5) members shall be Consumer Representatives – individuals who are receiving or have received mental health services **in California, preferably in Contra Costa County.**
- Five (5) members shall be Family Members – parents, spouses, State registered domestic **partners,** siblings or adult children of consumers who are receiving or have received mental health services **in California, preferably in Contra Costa County.**
- Five (5) members shall be Members-at-Large – individuals who have experience and knowledge of the mental health system **in California, preferably in Contra Costa County.**

C. The Commission membership should reflect the ethnic diversity of the client population in the County.

D. The composition of the Commission shall represent the demographics of the County as a whole, to the extent feasible.

E. No member of the Commission or his or her spouse shall be:

- A full-time or part-time employee of ~~the mental health service~~ **any Contra Costa County department that is directly involved in the provision of mental health services, or who has a potential conflict of interest. [NOTE: Point out to BOS in Board Order with justification if MHC does not want to revert to prior language]**

- An employee of the State Department of Mental Health; or
- An employee of, or a paid member of the governing body of a mental health contract agency.

F. Except as otherwise provided in Welfare & Institutions Code Section 5604(f), Commission members must be eighteen (18) years of age or older and reside in Contra Costa County.

G. Members of the Commission shall abstain from discussing or voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

SECTION 2. RESPONSIBILITY OF COMMISSION MEMBERS

Attendance requirements:

A. Regular attendance at Commission meetings is mandatory for all Commission members. ~~After three (3) absences, the Chairperson may contact the appointing Supervisor for appropriate action.~~ **A member who is absent, whether excused or unexcused, from three (3) Commission meetings in any twelve-month period shall be deemed to have automatically resigned from the Commission. In such event the member's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission's minutes. The Commission Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member's resignation and request the appointment of a replacement.**

~~B. Each member of the Commission shall serve on at least one standing committee of the Commission that meets on a monthly basis. If she/he does not choose a committee, the Chairperson shall appoint the Commissioner to a committee. Attendance requirements are the same as those pertaining to Commission meetings.~~

B. Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the full Commission.

C. The Chairperson may grant a Commission member a leave of absence, not to exceed three (3) consecutive regular monthly Commission meetings. A leave of absence may only be granted when the affected Commissioner requests it. To grant such a leave, the Chairperson shall announce it at a Commission meeting. The leave may become effective at the meeting at which it is announced. The leave waives the limitation of absences stated in Section 2, item A of this article. No more than two leaves of absence shall be afforded to said Commissioner during the Commissioner's term. Partial term appointments will be pro-rated.

SECTION 3. TERMS

The term of each member of the Commission shall be three (3) years in duration. Appointments shall be staggered so that approximately one-third (1/3) of the appointments end each year. All terms end on June 30 in the appropriate year. ~~There are no term limits.~~

No member shall serve more than four (4) consecutive three-year appointments. As of the date of adoption of these Bylaws, any member serving a fourth three-year appointment shall not be eligible for reappointment as a Commissioner. When one year has elapsed

following a former member's service on the Commission, of whatever duration that service was, he/she again becomes eligible for appointment. [NOTE: Point out to Board of Supervisors so they can determine whether they want to impose term limits]

The member of the Board of Supervisors who is appointed to the Commission shall serve a ~~three-year term~~ an unlimited term ~~or~~ until replaced by the ~~Board of Supervisors, on the recommendation of the~~ County Board of Supervisors.

SECTION 4. VACANCIES

The Chairperson ~~is obligated to declare a vacancy and direct the Executive Assistant to~~ shall notify the member of the Board of Supervisors who made the appointment and the Clerk of the Board if a Commission member ~~:~~

~~A.~~ R~~r~~esigns~~;~~.

~~C. Moves outside the County limits; or~~

~~E.~~ A. ~~Develops a conflict of interest as defined in Article III, Section 1, Subsection H.~~

~~Additionally, the Chairperson may request that the Executive Assistant notify the appropriate member of the Board of Supervisors if a Commissioner is absent from three (3) meetings during any calendar year (January through November).~~

SECTION 5. FILLING COMMISSION VACANCIES

Each member of the Board of Supervisors is encouraged to involve the Commission in all recruitment and screenings for applicants. Following an interview by the ~~Executive~~ Membership/Nominating Committee, the Committee will forward its recommendation to the Commission. After Commission approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for their action.

SECTION 6. COMMISSION RECRUITING PROCESS

In order to comply with Welfare and Institution Code membership mandates, the Commission shall receive applications on an ongoing basis.

ARTICLE IV
MEETINGS

SECTION 1. REGULAR MEETINGS

Meetings of the Mental Health Commission shall be held monthly. A minimum of eleven (11) meetings shall be held per year. If the regular meeting date falls on a holiday, a new meeting date shall be selected.

SECTION 2. ORDER OF BUSINESS

~~A.~~ Agendas shall be prepared for regular Commission and Executive Committee meetings at the direction of the Commission Chairperson(s). When feasible, ~~the Executive Assistant shall mail~~ agendas shall be distributed seven (7) days prior to the meeting. Agendas shall be posted, mailed and made available to the public in accordance with the Brown Act and Contra Costa County Better Government Ordinance.

~~B. Public Comment will be taken on each item on the agenda, in accordance with the Brown Act and the Contra Costa County Better Government Ordinance.~~

SECTION 3. QUORUM
A quorum shall be ~~a majority of the number of the currently filled seats on the Commission one person more than one-half of the appointed members~~a majority of the number of the currently filled seats on the Commission. The Commission must have a quorum present in order to hold a meeting.

SECTION 4. CLOSED SESSION
The Commission may not conduct closed sessions.

SECTION 5. SPECIAL MEETINGS
Special meetings of the Commission may be called at any time by the Chair or by a majority of the members of the Commission in accordance with the Brown Act.

SECTION 6. OPEN MEETINGS
All meetings of the Commission and all meetings of the standing committees, ~~subcommittees,~~ task forces and workgroups appointed by the Commission shall ~~be open to the public, in accordance~~ comply with the Brown Act and the County's Better Government Ordinance.

SECTION 7. DECISIONS AND ACTIONS OF THE COMMISSION
~~Unless otherwise stated, a~~All matters coming before the Commission for action shall be determined by a ~~vote of the majority of the appointed members present at the meeting~~simple majority vote of the total number of filled seats.

~~A simple majority vote is defined as the vote of the majority of the appointed members present at the meeting.~~

~~An absolute majority vote is defined as a vote of the majority of appointed members and is noted where required.~~ [NOTE: If this revision is not made the section must be pointed out in the Board Order with justification]

SECTION 8. ADDRESSING THE COMMISSION

~~Any person wishing to address the Commission shall give their name for the record. The Chairperson may set the total to be allowed for all speakers on any one subject and may limit the amount of time a person may use in addressing the Commission.~~

Public Comment shall be allowed on any items of interest to the public that is within the subject matter jurisdiction of the Commission, both agendized and non-agendized items, in accordance with the Brown Act and the Contra Costa County Better Government Ordinance. The Chairperson may limit the amount of time a person may use in addressing the Commission on any subject, provided the same amount of time is allotted to every person wishing to address the Commission.

ARTICLE V
ELECTION OF OFFICERS

SECTION 1. NOMINATION OF OFFICERS

~~The Executive Committee constitutes the Nominating Committee. The Nominating Committee shall select nominees for Chairperson and Vice-Chairperson of the Commission, obtain the nominees' consent to serve, and provide the slate of nominees to the Commission at their October meeting.~~

For annual appointment of Commission Chairperson, Vice Chairperson, and members of the Executive Committee, the Membership/Nominating Committee shall announce the solicitation of nominations from Commission members during the September meeting or the next regularly-scheduled meeting, obtain the nominees' consent to serve, and announce the slate of nominees at the October Commission meeting, or at the next regularly scheduled meeting. Should one of these positions become vacant during the term of office, nominations will be taken, nominees' consent to serve will be obtained, and nominees will be announced at the next regularly scheduled commission meeting.

SECTION 2. ELECTION

The Commission shall elect a Chairperson~~,~~ ~~and~~ Vice-Chairperson **and members of the Executive Committee** at the next regular meeting of the Commission ~~in November~~ **following the announcement of nominations as set forth in Section 1.** The newly-elected Chairperson~~,~~ ~~and~~ Vice-Chairperson **and members of the Executive Committee** shall assume office January 1 and serve through December 31 of that year. **In the case of a mid-term appointment, the elected Chair, Vice Chair or members of the Executive Committee will complete the remainder of the normal term.**

The election will be conducted publicly at the meeting. Each Commissioner will vote by submitting a signed ballot. At the meeting, the name of the Commissioner and his/her vote will be counted and announced by the Membership/Nominating Committee and recorded in the minutes through the use of signed ballots. Ballots will be announced and counted publicly by the Membership/Nominating Committee. The election of each officer will carry with a ~~simple~~ majority vote. In the case of a tie vote, the Membership/Nominating Committee shall hold elections during the next scheduled Commission meeting and the current seated officer will retain office until a new officer is elected.

At the request of the ~~Executive Committee~~ **Membership/Nominating Committee** and upon the approval of the Commission, Co-Chairpersons may be elected.

SECTION 3. REMOVAL

The Commission, by ~~an absolute~~ majority vote, may remove the Chairperson and/or Vice-Chairperson from office and relieve them of their duties. In the event of removal of the Chairperson and/or Vice-Chairperson, the ~~Executive Committee shall meet as the Nominating Committee~~ **Membership/Nominating Committee shall meet** and present nominations for the vacant position(s) at the next regularly scheduled Commission meeting.

ARTICLE VI
DUTIES OF OFFICERS

SECTION 1. DUTIES OF THE CHAIRPERSON
The Chairperson shall preside at all meetings of the Commission and perform duties consistent with these Bylaws, **the Welfare and Institutions Code and the Commission Policy and Procedure Manual.** The Chairperson will be in consultation with the local Mental Health Director.

The Chairperson shall conduct meetings, maintain order and decorum, and decide questions of procedure as required by the Brown Act and the Contra Costa County Better Government Ordinance.

In the event Co-Chairpersons are elected for the Commission, all the duties of the Chairperson will be divided between the Co-Chairpersons and all references to Chairperson herein will apply to the Co-Chairpersons.

The Chairperson shall appoint a representative, who may be either an officer or other member of the Commission, to the California Association of Local Mental Health Boards/Commissions. The duties of the representative to the statewide organization shall be to represent the Mental Health Commission at statewide meetings and to make regular reports to the Commission.

The Chairperson may not serve as a member of the Membership/Nominating Committee.

SECTION 2. DUTIES OF THE VICE CHAIRPERSON
In the event of the Chairperson's absence from a meeting of the Commission or inability to act, the Vice Chairperson shall preside and perform all duties of the Chairperson. In case of removal of the Chairperson, the Vice Chairperson shall perform all duties of the Chairperson until new elections can be held.

SECTION 3. TEMPORARY CHAIRPERSON
In the event both the Chairperson and Vice Chairperson are absent from a meeting of the Commission or unable to act, the members shall, by order fully entered into their records, elect one of their members to act as Chairperson Pro Tem. The Chairperson Pro Tem shall perform the duties of the Chairperson until such time as the Chairperson or Vice Chairperson resumes his or her duties.

ARTICLE VII
COMMITTEES

SECTION 1. CREATION OF COMMITTEES
Pursuant to the rules set forth herein, the Commission may create committees ~~as needed, including but not limited to standing committees, subcommittees and task forces.~~ **which can be standing committees, task forces or workgroups as needed. No more than four (4) Commission members should be appointed to any committee.**

~~Standing committees may be created by the Commission on its own motion. Subcommittees may be created by the Commission on the recommendation of a sponsoring standing committee. Task forces may be created by the Commission on its own motion or upon the recommendation of a sponsoring standing committee.~~

SECTION 2. STAFF ASSISTANCE ~~TO COMMITTEES~~

The staff of the Contra Costa County Mental Health Division shall serve in an advisory capacity to committees of the Commission. The Executive Assistant to the Commission will provide staff support to all committees.

SECTION 3. STANDING COMMITTEES

A. Mission Statement

Each standing committee shall develop a Mission Statement. The Mission Statement is subject to approval by the Commission, and shall be submitted to the Commission for approval no later than 60 days after establishment of the committee. The standing committees may include, but are not limited to, the following:

~~1. Adult & Transitional Age Young Committee~~
~~2. Children's Committee~~
~~3. Executive/Finance Committee~~
~~4. Justice System Committee~~
~~5. Older Adult Committee~~
1. Executive Committee
2. Membership/Nominating Committee
4.3.Other Standing Committees as established by the Commission

B. Membership

~~With the exception of the Executive Committee,~~ The membership of each standing committee shall include a minimum of two (2) **and a maximum of four (4)** members of the Commission.

C. Appointment and Terms

1. The Commission Chairperson may appoint Commission members to standing committees **in accordance with the Commission's Policy and Procedures Manual.**
3.2. The terms of the Committee Chairpersons and Vice Chairpersons shall be one (1) year. There are no limits on the number of terms an individual may serve as Chairperson.

D. Meetings/Actions

1. All matters coming before a standing committee shall be determined by a majority of the Commission members voting, subject to approval by the Commission.
3.2. All standing committee meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance. ~~With the exception of the Executive Committee, two (2) members of the Commission shall constitute a quorum for the transaction of business.~~

E. Chairpersons/Co-Chairpersons/Vice Chairpersons

1. Selection
   1 Each standing committee shall have a Chairperson and may have a Co- or Vice Chairperson. Chairpersons and Co- or Vice Chairpersons of standing

committees must be Commission members. They are selected by the Commission Chairperson, subject to approval by the Commission.

32 In the event of a vacancy in the position of Chairperson of a standing committee, the Commission Chairperson may serve as temporary Chairperson of the standing committee for up to ninety (90) days. If the position remains vacant for more than 90 days, the standing committee shall go into abeyance until a Chairperson is appointed.

2. Duties

1 The Chairperson shall preside at all meetings of the standing committee and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall be in consultation with the Commission Chairperson.

32 The Chairperson shall direct the preparation and distribution of agendas for the standing committee.

53 The Chairperson shall provide monthly reports to the Commission regarding the activities of the standing committee, and is encouraged to provide an outline of the monthly report to the Executive Assistant to the Commission for use in preparation of the Minutes.

74 The Chairperson shall conform to the Mental Health Division client confidentiality statement and ensure that members and attendees of the standing committee do likewise.

~~F. Executive Committee~~

1. ~~Members of the Executive Committee shall include, but are not limited to the Commission Chairperson, Co-Chairperson (if any), and Vice Chairperson and the Chairpersons, or their designees (who must be Commissioners), of each standing committee.~~

~~3.2.~~ ~~At the request of the Commission Chairperson, the Commission may authorize the Executive Committee to act in place of the Commission.~~

~~5.3.~~ ~~One (1) person more than half the specified members of the Executive Committee, above, shall constitute a quorum. Any and all actions of the Executive Committee are subject to ratification at the next regular meeting of the Commission.~~

SECTION 4. EXECUTIVE COMMITTEE

A. Mission Statement

The Executive Committee is charged with acting on the decisions of the full Mental Health Commission. Its primary focus is to identify and avail any reasonable resources needed to deliberate over agenda items of the general membership, workgroup, committee or task force meeting.

B. Membership

Members of the Executive Committee shall include the Commission Chairperson, Co-Chairperson (if any), and Vice Chairperson. Additional member(s) will be elected by the Commission for a term of one calendar year. The Executive Committee shall consist of a maximum of four (4) members.

SECTION 5 MEMBERSHIP/NOMINATING COMMITTEE

A. Mission Statement

The Membership/Nominating Committee shall interview applicants to the Commission. Following the interview, the Committee will forward its recommendation to the Commission. After Commission approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for their action.
The Membership/Nominating Committee shall also select nominees for Chairperson, Vice Chairperson, and members of the Executive Committee, obtain the nominees' consent to serve, and provide the slate of nominees to the Commission.

B. Membership
Members of the Membership/Nominating Committee shall be the Commission Vice Chairperson and three (3) additional Commissioners. The Commission Chairperson may not serve on the Membership/Nominating Committee. The Membership/Nominating Committee shall consist of a maximum of four (4) members.

SECTION 6. TASK FORCES

A. Purpose
Task Forces shall be time-limited and have a stated purpose approved by the Commission **and shall be required to report back to the Commission regarding progress toward their stated purpose.**

B. Membership of Task Forces
The membership of each task force shall include a minimum of two (2) **but no more than four (4)** members of the Commission who shall serve on the task force as liaisons to the Commission. **Other members may be appointed from the community when special expertise, advice or opinion is desired, at the discretion of the Commission.** All members and attendees shall conform to the Mental Health Division client confidentiality statement. [NOTE: MUST BE POINTED OUT AND JUSTIFICATION PROVIDED IN BOARD ORDER – COUNTY COUNSEL RECOMMENDS PLACING A LIMIT ON THE NUMBER OF COMMUNITY MEMBERS – CAO RECOMMENDS THAT THERE NOT BE MORE COMMUNITY MEMBERS THAN COMMISSION MEMBERS]

C. Appointment and Terms
The Commission shall appoint ~~Commission~~ members to task forces upon the recommendation of the ~~sponsoring standing committee, if any, or Executive Committee~~ **Commission**. The terms of all task force members~~, including the Chairperson,~~ shall be ~~six (6) months, or~~ until the task force has completed its mission~~, whichever comes first.~~

E. Meetings/Actions
A minimum of two (2) Commissioners**, or 50% of the membership plus one individual, whichever is more,** shall constitute a quorum for the transaction of business. All matters coming before task force shall be determined by a ~~simple~~ majority of the members voting~~, subject to approval by the sponsoring standing committee, if any,~~ and Commission. All ~~task force~~ meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance.

F. Chairpersons/Co-Chairpersons

1. Selection
   Each task force shall have a Chairperson, ~~appointed by the Commission on the recommendation of the sponsoring standing committee, if any, or Executive Committee.~~ **selected by the members of the task force.** The Chair of an task force must be a Commission member. In the event of a vacancy in the position of Chairperson of task force, the ~~sponsoring committee~~ **Commission** Chairperson may serve as temporary Chairperson of the task force for up to 90 days. If the position remains vacant for more than 90 days, the task force shall go into abeyance until a Chairperson is appointed.
2. Duties
   - ☐ The Chairperson shall preside at all meetings of the task force and perform his or her duties consistent with the procedures outlined herein. The Chair shall be in consultation with the Commission Chairperson.
   - ☐ The Chairperson shall direct the preparation and distribution of agendas for the task force.
   - ☐ The Chairperson shall provide monthly reports to the ~~sponsoring standing committee, if any, or~~ Commission.
   - ~~☐ The Chairperson shall conform to the Mental Health Division client confidentiality statement and ensure that members and attendees of the subcommittee do likewise.~~

SECTION 7. WORKGROUPS

A. Purpose
Workgroups shall be time-limited and have a stated purpose approved by the Commission and shall be required to report back to the Commission regarding progress toward their stated purpose.

B. Membership of the Workgroup
The membership of a workgroup will consist of a minimum of two (2) but no more than four (4) members of the Commission.

C. Appointment and Terms
The Commission shall appoint Commission members to a workgroup upon the recommendation of the Commission in accordance with the Commission Policy and Procedures Manual.

D. Meetings/Actions
A minimum of two (2) Commissioners, or 50% of the membership plus one individual, whichever is more, shall constitute a quorum for the transaction of business. All matters coming before a workgroup shall be determined by a simple majority of the members and Commission.

E. Chairpersons/Co-Chairpersons

1. Selection
Each workgroup shall have a Chairperson, appointed by the Commission Chairperson. In the event of a vacancy in the position of Chairperson of a workgroup, the Commission Chairperson may serve as temporary Chairperson of the task force for up to 90 days. If the position remains vacant for more than 90 days, the workgroup shall go into abeyance until a Chairperson is appointed.

2. Duties
   - The Chairperson shall preside at all meetings of the workgroup and perform his or her duties consistent with the procedures outlined herein. The Chair shall be in consultation with the Commission Chairperson.
   - The Chairperson shall direct the preparation and distribution of agendas for the workgroup.
   - The Chairperson shall provide monthly reports to the Commission.

ARTICLE VIII
COMMISSION POLICY AND PROCEDURE MANUAL

A. Purpose
Establish policies and procedure within which the Commission will operate. None of these guidelines can be established to nullify or circumvent these Bylaws, the Welfare and Institutions Code or any other prevailing laws and statutes.

B. Establishment and Amendment of these Policies and Procedures
The Policies and Procedures are established and amended by an absolute majority vote during a regular Commission meeting.
[NOTE – COUNTY COUNSEL RECOMMENDS MENTAL HEALTH DIRECTOR REVIEW MANUAL TO ENSURE THAT IT IS LIMITED TO PROCEDURAL MATTERS]

ARTICLE IX
COMMISSION/MENTAL HEALTH DIVISION RELATIONSHIP

SECTION 1. STAFF SUPPORT
The Mental Health Division shall provide for administrative and clerical support services to manage the operations and activities of the Mental Health Commission. The budget of the Mental Health Division shall fund the position of the Executive Assistant to the Mental Health Commission.

SECTION 2. MENTAL HEALTH STAFF ATTENDANCE AT MEETINGS
The Mental Health Division staff shall provide information to the Commission, or to committees, regarding agenda items and attend meetings on a regular basis. ~~The Commission requests that appropriate staff members or their designees regularly attend the following meetings:~~

~~1. Adult & Transitional Age Youth Committee – Adult/Older Adult Mental Health Program Chief~~
~~3.2. Children's Committee – Children/Adolescent Mental Health Program Chief~~
~~5.3. Executive/Finance Committee – Mental Health Director and Health Services Financial Director~~
~~7.4. Justice System Committee – Adult/Older Adult Mental Health Program Chief~~
~~9.5. Mental Health Commission – Mental Health Director~~
~~11.6. Older Adult Committee – Adult/Older Adult Mental Health Program Chief~~

SECTION 3. ACTIONS
The Commission shall regularly inform the Director of Mental Health Services of Commission

actions.

ARTICLE X
BYLAW AMENDMENTS

SECTION 1. AMENDMENTS
These bylaws may be amended by ~~an absolute~~ majority vote ~~of the appointed members~~ in a regularly scheduled meeting as defined at Article IV, Section 1. Before the Commission may consider and/or vote on Bylaw amendments, proposed amendments shall be submitted in writing to Commission members at least thirty (30) days prior to the meeting date at which they are to be considered. Amended Bylaws shall be submitted to County Counsel for review, finalized by the Commission and then transmitted to the Board of Supervisors for final approval.

Revised Draft – with Mental Health Commission Bylaws Workgroup's Recommendation – 3-30-10

Revised Draft – with County Counsel's Recommended Changes 7-14-09
Final Draft Revisions -- Approved at Special Mental Health Commission Meeting 4/6/2009

Plain, black text = No changes in original text.
~~Red strikethroughs~~ = Proposed deletions of original text.
Bold, yellow highlighted = Proposed changes and/or additions to original text.

ARTICLE I
NAME OF ORGANIZATION

SECTION 1. NAME OF ORGANIZATION
The name of the organization shall be the "Contra Costa County Mental Health Commission."

ARTICLE II
GENERAL PROVISIONS

SECTION 1. AUTHORITY
The Contra Costa County Mental Health Commission ("Commission" hereinafter) was established by order of the Contra Costa County Board of Supervisors on June 22, 1993, pursuant to the Bronzan-McCorquodale Act, Stats. 1992, c. 1374 (AB. 14)~~, also known as the Welfare and Institutions Code Section 5604. Additional authorities were bestowed upon the Mental Health Commission by the Mental Health Services Act Section 5800.~~

SECTION 2. ROLES AND RESPONSIBILITY
As specified in the Welfare and Institutions Code Sections 5600 and 5800.
~~The Commission shall:~~

~~A. Review and evaluate the community's mental health needs, services, facilities, and special problems.~~

~~B. Review and County agreements entered into pursuant to Welfare & Institutions Code 5650.~~

~~C. Advise the Board of Supervisors and the Contra Costa County Mental Health Director as to any aspect of the local mental health program.~~

~~D. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.~~

~~E. Submit an Annual Report to the Board of Supervisors on the needs and performance of the County's mental health system.~~

~~F. Review and make recommendations on applicants for the appointment of Contra Costa County Director of Mental Health Services. The Commission shall be included in the selection process prior to the vote of the Board of Supervisors.~~

~~G. Review and comment on the County's performance outcome data and communicate its findings to the California Mental Health Planning Council.~~

~~H. Perform other duties as authorized by the Board of Supervisors.~~

~~As part of its duties set forth above, the Commission shall assess the impact of the realignment of~~

~~services from the State to the County, on services delivered to clients and in the local community.~~

ARTICLE III
MEMBERSHIP

SECTION 1. MEMBERSHIP

The Commission shall consist of fifteen (15) members appointed by the Board of Supervisors, plus one member of the Board of Supervisors and an alternate assigned to be a representative to the Commission. Each member of the Board of Supervisors shall have three (3) members representing his or her district. The specific seat to be assigned to each nominee will be determined by the member of the Board of Supervisors making the nomination.

The following rules shall apply to membership of the Commission:

A. One (1) member of the Board of Supervisors shall be a member of the Commission~~, as required by Welfare and Institutions Code Section 5604.~~ The Board of Supervisors shall also appoint one (1) Supervisor to serve as an alternate member.

B. Pursuant to the Welfare & Institutions Code Section 5604, fifty percent (50%) of the Commission membership "shall be consumers or parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services." ~~Membership is divided equally among the five (5) districts. However, should Consumer or Family Member commissioners fall below the twenty (20%) minimum per category or fifty percent (50%) total, as required by the Welfare & Institutions Code, applicants shall be considered from other districts, if available.~~ **If at least twenty percent of the total commission membership are not Consumers and/or if at least twenty percent of the total commission membership are not Family Members, a commissioner for the underrepresented category may be selected from any Supervisorial district, if there are no applicants from the impacted district.** On this Mental Health Commission, membership shall consist of:

- Five (5) members shall be Consumer Representatives – individuals who are receiving or have received mental health services **in California, preferably in Contra Costa County.**
- Five (5) members shall be Family Members – parents, spouses, State registered domestic **partners**, siblings or adult children of consumers who are receiving or have received mental health services **in California, preferably in Contra Costa County.**
- Five (5) members shall be Members-at-Large – individuals who have experience and knowledge of the mental health system **in California, preferably in Contra Costa County.**

C. The Commission membership should reflect the ethnic diversity of the client population in the County.

D. The composition of the Commission shall represent the demographics of the County as a whole, to the extent feasible.

E. No member of the Commission or his or her spouse shall be:

- A full-time or part-time employee of ~~the mental health service~~ **any Contra Costa County department that is directly involved in the provision of mental health services~~, or who has a potential conflict of interest.~~**

- An employee of the State Department of Mental Health; or
- An employee of, or a paid member of the governing body of a mental health contract agency.

F. Except as otherwise provided in Welfare & Institutions Code Section 5604(f), Commission members must be eighteen (18) years of age or older and reside in Contra Costa County.

G. Members of the Commission shall abstain from discussing or voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

SECTION 2. RESPONSIBILITY OF COMMISSION MEMBERS

Attendance requirements:

A. Regular attendance at Commission meetings is mandatory for all Commission members. ~~After three (3) absences, the Chairperson may contact the appointing Supervisor for appropriate action.~~ **A member who is absent, whether excused or unexcused, from three (3) Commission meetings in any twelve-month period shall be deemed to have automatically resigned from the Commission. In such event the member's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission's minutes. The Commission Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member's resignation and request the appointment of a replacement.**

~~B. Each member of the Commission shall serve on at least one standing committee of the Commission that meets on a monthly basis. If she/he does not choose a committee, the Chairperson shall appoint the Commissioner to a committee. Attendance requirements are the same as those pertaining to Commission meetings.~~

B. Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the full Commission.

C. The Chairperson may grant a Commission member a leave of absence, not to exceed three (3) consecutive regular monthly Commission meetings. A leave of absence may only be granted when the affected Commissioner requests it. To grant such a leave, the Chairperson shall announce it at a Commission meeting. The leave may become effective at the meeting at which it is announced. The leave waives the limitation of absences stated in Section 2, item A of this article. No more than two leaves of absence shall be afforded to said Commissioner during the Commissioner's term. Partial term appointments will be pro-rated.

SECTION 3. TERMS

The term of each member of the Commission shall be three (3) years in duration. Appointments shall be staggered so that approximately one-third (1/3) of the appointments end each year. All terms end on June 30 in the appropriate year. ~~There are no term limits.~~

No member shall serve more than four (4) consecutive three-year appointments. As of the date of adoption of these Bylaws, any member serving a fourth three-year appointment shall not be eligible for reappointment as a Commissioner. When one year has elapsed

following a former member's service on the Commission, of whatever duration that service was, he/she again becomes eligible for appointment.

[NOTE: Point out to Board of Supervisors so they can determine whether they want to impose term limits]

The member of the Board of Supervisors who is appointed to the Commission shall serve ~~a three-year term~~ **an unlimited** term ~~or~~ until replaced by the ~~Board of Supervisors, on the recommendation of the~~ County Board of Supervisors.

SECTION 4. VACANCIES

The Chairperson ~~is obligated to declare a vacancy and direct the Executive Assistant to~~ **shall** notify the member of the Board of Supervisors who made the appointment and the Clerk of the Board if a Commission member ~~:~~

~~R~~resigns~~;~~.

~~Moves outside the County limits; or~~

~~Develops a conflict of interest as defined in Article III, Section 1, Subsection H.~~

~~Additionally, the Chairperson may request that the Executive Assistant notify the appropriate member of the Board of Supervisors if a Commissioner is absent from three (3) meetings during any calendar year (January through November).~~

SECTION 5. FILLING COMMISSION VACANCIES

Each member of the Board of Supervisors is encouraged to involve the Commission in all recruitment and screenings for applicants. Following an interview by the ~~Executive~~ **Membership/Nominating** Committee, the Committee will forward its recommendation to the Commission. After Commission approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for their action.

SECTION 6. COMMISSION RECRUITING PROCESS

In order to comply with Welfare and Institution Code membership mandates, the Commission shall receive applications on an ongoing basis.

ARTICLE IV
MEETINGS

SECTION 1. REGULAR MEETINGS

Meetings of the Mental Health Commission shall be held monthly. A minimum of eleven (11) meetings shall be held per year. If the regular meeting date falls on a holiday, a new meeting date shall be selected.

SECTION 2. ORDER OF BUSINESS

~~A.~~ Agendas shall be prepared for regular Commission and Executive Committee meetings at the direction of the Commission Chairperson**(s)**. When feasible, ~~the Executive Assistant shall mail~~ agendas **shall be distributed** seven (7) days prior to the meeting. Agendas shall be posted, mailed and made available to the public in accordance with the Brown Act and Contra Costa **County** Better Government Ordinance.

~~B. Public Comment will be taken on each item on the agenda, in accordance with the Brown Act and the Contra Costa County Better Government Ordinance.~~

SECTION 3. QUORUM

A quorum shall be a majority of the number of the currently filled seats on the Commission ~~**one person more than one-half of the appointed members**~~. The Commission must have a quorum present in order to hold a meeting.

SECTION 4. CLOSED SESSION

The Commission may not conduct closed sessions.

SECTION 5. SPECIAL MEETINGS

Special meetings of the Commission may be called at any time by the Chair or by a majority of the members of the Commission in accordance with the Brown Act.

SECTION 6. OPEN MEETINGS

All meetings of the Commission and all meetings of the standing **committees,** ~~subcommittees,~~ task forces **and workgroups** appointed by the Commission shall ~~be open to the public, in accordance~~ **comply with the Brown Act and the County's Better Government Ordinance.**

SECTION 7. DECISIONS AND ACTIONS OF THE COMMISSION

Unless otherwise stated, all matters coming before the Commission for action shall be determined by a ~~vote of the majority of the appointed members present at the meeting~~ **simple majority vote.**

A simple majority vote is defined as the vote of the majority of the appointed members present at the meeting.

An absolute majority vote is defined as a vote of the majority of appointed members and is noted where required.

[NOTE: If this revision is not made the section must be pointed out in the Board Order with justification]

[NOTE: THE COMMISSION IS NOT PROPOSING CHANGES IN THE INTENT OF THE BYLAWS; RATHER PROPOSING USING EXPLICIT TERMS TO REMOVE THE AMBIGUITY WHICH HAS CAUSED PROBLEMS IN THE PAST.

SECTION 8. ADDRESSING THE COMMISSION

~~Any person wishing to address the Commission shall give their name for the record. The Chairperson may set the total to be allowed for all speakers on any one subject and may limit the amount of time a person may use in addressing the Commission.~~

Public Comment shall be allowed on any items of interest to the public that is within the subject matter jurisdiction of the Commission, both agendized and non-agendized items, in accordance

with the Brown Act and the Contra Costa County Better Government Ordinance. **The Chairperson may limit the amount of time a person may use in addressing the Commission on any subject, provided the same amount of time is allotted to every person wishing to address the Commission.**

ARTICLE V
ELECTION OF OFFICERS

SECTION 1. NOMINATION OF OFFICERS

~~The Executive Committee constitutes the Nominating Committee. The Nominating Committee shall select nominees for Chairperson and Vice Chairperson of the Commission, obtain the nominees' consent to serve, and provide the slate of nominees to the Commission at their October meeting.~~

For annual appointment of Commission Chairperson, Vice Chairperson, and members of the Executive Committee, the Membership/Nominating Committee shall announce the solicitation of nominations from Commission members during the September meeting or the next regularly-scheduled meeting, obtain the nominees' consent to serve, and announce the slate of nominees at the October Commission meeting, or at the next regularly scheduled meeting. Should one of these positions become vacant during the term of office, nominations will be taken, nominees' consent to serve will be obtained, and nominees will be announced at the next regularly scheduled commission meeting.

SECTION 2. ELECTION

The Commission shall elect a Chairperson, ~~and~~ Vice-Chairperson **and members of the Executive Committee** at the **next** regular meeting of the Commission ~~in November~~ **following the announcement of nominations as set forth in Section I.** The newly-elected Chairperson, ~~and~~ Vice-Chairperson **and members of the Executive Committee** shall assume office January 1 and serve through December 31 of that year. **In the case of a mid-term appointment, the elected Chair, Vice Chair or members of the Executive Committee will complete the remainder of the normal term.**

The election will be conducted publicly ~~at the meeting. Each Commissioner will vote by submitting a signed ballot. At the meeting, the name of the Commissioner and his/her vote will be counted and announced by the Membership/Nominating Committee and recorded in the minutes.~~through the use of signed ballots. Ballots will be announced and counted publicly by the Membership/Nominating Committee. The election of each officer will carry with a simple majority vote. In the case of a tie vote, the Membership/Nominating Committee shall hold elections during the next scheduled Commission meeting and the current seated officer will retain office until a new officer is elected.

At the request of the ~~Executive Committee~~ **Membership/Nominating Committee** and upon the approval of the Commission, Co-Chairpersons may be elected.

SECTION 3. REMOVAL

The Commission, by an **absolute** majority vote, may remove the Chairperson and/or Vice-

Chairperson from office and relieve them of their duties. In the event of removal of the Chairperson and/or Vice-Chairperson, the ~~Executive Committee shall meet as the Nominating Committee~~ **Membership/Nominating Committee shall meet** and present nominations for the vacant position(s) at the next regularly scheduled Commission meeting.

ARTICLE VI
DUTIES OF OFFICERS

SECTION 1. DUTIES OF THE CHAIRPERSON

The Chairperson shall preside at all meetings of the Commission and perform duties consistent with these Bylaws, **the Welfare and Institutions Code and the Commission Policy and Procedure Manual.** The Chairperson will be in consultation with the local Mental Health Director.

The Chairperson shall conduct meetings, maintain order and decorum, and decide questions of procedure as required by the Brown Act and the Contra Costa County Better Government Ordinance.

In the event Co-Chairpersons are elected for the Commission, all the duties of the Chairperson will be divided between the Co-Chairpersons and all references to Chairperson herein will apply to the Co-Chairpersons.

The Chairperson shall appoint a representative, who may be either an officer or other member of the Commission, to the California Association of Local Mental Health Boards/Commissions. The duties of the representative to the statewide organization shall be to represent the Mental Health Commission at statewide meetings and to make regular reports to the Commission.

The Chairperson may not serve as a member of the Membership/Nominating Committee.

SECTION 2. DUTIES OF THE VICE CHAIRPERSON

In the event of the Chairperson's absence from a meeting of the Commission or inability to act, the Vice Chairperson shall preside and perform all duties of the Chairperson. In case of removal of the Chairperson, the Vice Chairperson shall perform all duties of the Chairperson until new elections can be held.

SECTION 3. TEMPORARY CHAIRPERSON

In the event both the Chairperson and Vice Chairperson are absent from a meeting of the Commission or unable to act, the members shall, by order fully entered into their records, elect one of their members to act as Chairperson Pro Tem. The Chairperson Pro Tem shall perform the duties of the Chairperson until such time as the Chairperson or Vice Chairperson resumes his or her duties.

ARTICLE VII
COMMITTEES

SECTION 1. CREATION OF COMMITTEES

Pursuant to the rules set forth herein, the Commission may create committees ~~as needed, including but not limited to standing committees, subcommittees and task forces.~~ **which can be standing committees, task forces or workgroups as needed. No more than four (4) Commission members should be appointed to any committee.**

~~Standing committees may be created by the Commission on its own motion. Subcommittees may be created by the Commission on the recommendation of a sponsoring standing committee. Task forces may be created by the Commission on its own motion or upon the recommendation of a sponsoring standing committee.~~

SECTION 2. STAFF ASSISTANCE ~~TO COMMITTEES~~

The staff of the Contra Costa County Mental Health Division shall serve in an advisory capacity to committees of the Commission. The Executive Assistant to the Commission will provide staff support to all committees.

SECTION 3. STANDING COMMITTEES

A. Mission Statement

Each standing committee shall develop a Mission Statement. The Mission Statement is subject to approval by the Commission, and shall be submitted to the Commission for approval no later than 60 days after establishment of the committee. The standing committees may include, but are not limited to, the following:

~~1. Adult & Transitional Age Young Committee~~
~~2. Children's Committee~~
~~3. Executive/Finance Committee~~
~~4. Justice System Committee~~
~~5. Older Adult Committee~~

1. Executive Committee
2. Membership/Nominating Committee
~~4.~~3.Other Standing Committees as established by the Commission

B. Membership

~~With the exception of the Executive Committee,~~ The membership of each standing committee shall include a minimum of two (2) **and a maximum of four (4)** members of the Commission.

C. Appointment and Terms

1. The Commission Chairperson may appoint Commission members to standing committees **in accordance with the Commission's Policy and Procedures Manual.**
~~3.~~2. The terms of the Committee Chairpersons and Vice Chairpersons shall be one (1) year. There are no limits on the number of terms an individual may serve as Chairperson.

D. Meetings/Actions

1. All matters coming before a standing committee shall be determined by a majority of the Commission members voting, subject to approval by the Commission.
~~3.~~2. All standing committee meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance. ~~With the exception of the Executive Committee, two (2) members of the Commission shall constitute a~~

~~quorum for the transaction of business.~~

E. Chairpersons/Co-Chairpersons/Vice Chairpersons

1. Selection

1 Each standing committee shall have a Chairperson and may have a Co- or Vice Chairperson. Chairpersons and Co- or Vice Chairpersons of standing committees must be Commission members. They are selected by the Commission Chairperson, subject to approval by the Commission.

~~3~~2 In the event of a vacancy in the position of Chairperson of a standing committee, the Commission Chairperson may serve as temporary Chairperson of the standing committee for up to ninety (90) days. If the position remains vacant for more than 90 days, the standing committee shall go into abeyance until a Chairperson is appointed.

2. Duties

1 The Chairperson shall preside at all meetings of the standing committee and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall be in consultation with the Commission Chairperson.

~~3~~2 The Chairperson shall direct the preparation and distribution of agendas for the standing committee.

~~5~~3 The Chairperson shall provide monthly reports to the Commission regarding the activities of the standing committee, and is encouraged to provide an outline of the monthly report to the Executive Assistant to the Commission for use in preparation of the Minutes.

~~7~~4 The Chairperson shall conform to the Mental Health Division client confidentiality statement and ensure that members and attendees of the standing committee do likewise.

~~F. Executive Committee~~

1. ~~Members of the Executive Committee shall include, but are not limited to the Commission Chairperson, Co-Chairperson (if any), and Vice Chairperson and the Chairpersons, or their designees (who must be Commissioners), of each standing committee.~~

~~3.2.At the request of the Commission Chairperson, the Commission may authorize the Executive Committee to act in place of the Commission.~~

~~5.3.One (1) person more than half the specified members of the Executive Committee, above, shall constitute a quorum. Any and all actions of the Executive Committee are subject to ratification at the next regular meeting of the Commission.~~

SECTION 4. EXECUTIVE COMMITTEE

A. Mission Statement

The Executive Committee is charged with acting on the decisions of the full Mental Health Commission. Its primary focus is to identify and avail any reasonable resources needed to deliberate over agenda items of the general membership, workgroup, committee or task force meeting.

B. Membership

Members of the Executive Committee shall include the Commission Chairperson, Co-Chairperson (if any), and Vice Chairperson. Additional member(s) will be

elected by the Commission for a term of one calendar year. The Executive Committee shall consist of a maximum of four (4) members.

SECTION 5 MEMBERSHIP/NOMINATING COMMITTEE

A. Mission Statement

The Membership/Nominating Committee shall interview applicants to the Commission. Following the interview, the Committee will forward its recommendation to the Commission. After Commission approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for their action.
The Membership/Nominating Committee shall also select nominees for Chairperson, Vice Chairperson, and members of the Executive Committee, obtain the nominees' consent to serve, and provide the slate of nominees to the Commission.

B. Membership

Members of the Membership/Nominating Committee shall be the Commission Vice Chairperson and three (3) additional Commissioners. The Commission Chairperson may not serve on the Membership/Nominating Committee. The Membership/Nominating Committee shall consist of a maximum of four (4) members.

SECTION 6. TASK FORCES

A. Purpose

Task Forces shall be time-limited and have a stated purpose approved by the Commission **and shall be required to report back to the Commission regarding progress toward their stated purpose.**

B. Membership **of Task Forces**

The membership of each task force shall include a minimum of two (2) **but no more than four (4)** members of the Commission who shall serve on the task force as liaisons to the Commission. **Other members may be appointed from the community when special expertise, advice or opinion is desired, at the discretion of the Commission.** All members and attendees shall conform to the Mental Health Division client confidentiality statement. [NOTE: MUST BE POINTED OUT AND JUSTIFICATION PROVIDED IN BOARD ORDER – COUNTY COUNSEL RECOMMENDS PLACING A LIMIT ON THE NUMBER OF COMMUNITY MEMBERS – CAO RECOMMENDS THAT THERE NOT BE MORE COMMUNITY MEMBERS THAN COMMISSION MEMBERS]

C. Appointment and Terms

The Commission shall appoint ~~Commission~~ members to task forces upon the recommendation of the ~~sponsoring standing committee, if any, or Executive Committee~~ **Commission**. The terms of all task force members~~, including the Chairperson,~~ shall be ~~six (6) months, or~~ until the task force has completed its mission~~, whichever comes first~~.

E. Meetings/Actions

A minimum of two (2) Commissioners, **or 50% of the membership plus one individual, whichever is more,** shall constitute a quorum for the transaction of business.

All matters coming before task force shall be determined by a **simple** majority of the members voting~~, subject to approval by the sponsoring standing committee, if any,~~ and Commission. All ~~task force~~ meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance.

F. Chairpersons/Co-Chairpersons

1. Selection

Each task force shall have a Chairperson, ~~appointed by the Commission on the recommendation of the sponsoring standing committee, if any, or Executive Committee.~~ **selected by the members of the task force.** The Chair of a task force must be a Commission member. In the event of a vacancy in the position of Chairperson of task force, the ~~sponsoring committee~~ **Commission** Chairperson may serve as temporary Chairperson of the task force for up to 90 days. If the position remains vacant for more than 90 days, the task force shall go into abeyance until a Chairperson is appointed.

2. Duties

The Chairperson shall preside at all meetings of the task force and perform his or her duties consistent with the procedures outlined herein. The Chair shall be in consultation with the Commission Chairperson.

The Chairperson shall direct the preparation and distribution of agendas for the task force.

The Chairperson shall provide monthly reports to the ~~sponsoring standing committee, if any, or~~ Commission.

~~The Chairperson shall conform to the Mental Health Division client confidentiality statement and ensure that members and attendees of the subcommittee do likewise.~~

SECTION 7. WORKGROUPS

A. Purpose

Workgroups shall be time-limited and have a stated purpose approved by the Commission and shall be required to report back to the Commission regarding progress toward their stated purpose.

B. Membership of the Workgroup

The membership of a workgroup will consist of a minimum of two (2) but no more than four (4) members of the Commission.

C. Appointment and Terms

The Commission shall appoint Commission members to a workgroup upon the recommendation of the Commission in accordance with the Commission Policy and Procedures Manual.

D. Meetings/Actions

A minimum of two (2) Commissioners, or 50% of the membership plus one individual, whichever is more, shall constitute a quorum for the transaction of business. All matters coming before a workgroup shall be determined by a simple majority of the members and Commission.

E. Chairpersons/Co-Chairpersons

1. Selection

Each workgroup shall have a Chairperson, appointed by the Commission Chairperson. In the event of a vacancy in the position of Chairperson of a workgroup, the Commission Chairperson may serve as temporary Chairperson of the task force for up to 90 days. If the position remains vacant for more than 90 days, the workgroup shall go into abeyance until a Chairperson is appointed.

2. **Duties**

The Chairperson shall preside at all meetings of the workgroup and perform his or her duties consistent with the procedures outlined herein. The Chair shall be in consultation with the Commission Chairperson.

The Chairperson shall direct the preparation and distribution of agendas for the workgroup.

The Chairperson shall provide monthly reports to the Commission.

ARTICLE VIII
COMMISSION POLICY AND PROCEDURE MANUAL

A. Purpose

Establish policies and procedure within which the Commission will operate. None of these guidelines can be established to nullify or circumvent these Bylaws, the Welfare and Institutions Code or any other prevailing laws and statutes.

B. Establishment and Amendment of these Policies and Procedures

The Policies and Procedures are established and amended by an absolute majority vote during a regular Commission meeting.

[NOTE – COUNTY COUNSEL RECOMMENDS MENTAL HEALTH DIRECTOR REVIEW MANUAL TO ENSURE THAT IT IS LIMITED TO PROCEDURAL MATTERS]

ARTICLE IX
COMMISSION/MENTAL HEALTH DIVISION RELATIONSHIP

SECTION 1. STAFF SUPPORT

The Mental Health Division shall provide for administrative and clerical support services to manage the operations and activities of the Mental Health Commission. The budget of the Mental Health Division shall fund the position of the Executive Assistant to the Mental Health Commission.

SECTION 2. MENTAL HEALTH STAFF ATTENDANCE AT MEETINGS

The Mental Health Division staff shall provide information to the Commission, or to committees, regarding agenda items and attend meetings on a regular basis. ~~The Commission requests that appropriate staff members or their designees regularly attend the following meetings:~~

~~1. Adult & Transitional Age Youth Committee – Adult/Older Adult Mental Health Program Chief~~

~~3.2.Children's Committee – Children/Adolescent Mental Health Program Chief~~

~~5.3.Executive/Finance Committee – Mental Health Director and Health Services Financial Director~~

~~7.4.Justice System Committee – Adult/Older Adult Mental Health Program Chief~~
~~9.5.Mental Health Commission – Mental Health Director~~
~~11.6.Older Adult Committee – Adult/Older Adult Mental Health Program Chief~~

SECTION 3. ACTIONS
The Commission shall regularly inform the Director of Mental Health Services of Commission actions.

ARTICLE X
BYLAW AMENDMENTS

SECTION 1. AMENDMENTS
These bylaws may be amended by **an absolute** majority vote ~~of the appointed members~~ in a regularly scheduled meeting as defined at Article IV, Section 1. Before the Commission may consider and/or vote on Bylaw amendments, proposed amendments shall be submitted in writing to Commission members at least thirty (30) days prior to the meeting date at which they are to be considered. Amended Bylaws shall be submitted to County Counsel for review, finalized by the Commission and then transmitted to the Board of Supervisors for final approval.