Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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Contra Costa County Mental Health Commission Monthly Meeting
Wednesday, June7, 2017 ♦ 4:30pm to 6:30 p.m.
AT: 550 Ellinwood Way in Pleasant Hill

AGENDA

I. **Call to Order / Introductions/Roll call- Chair**

II. **Chair- Announcements and Comments**

- **Amendment to MHC Bylaws regarding membership applicants**
- **MHC communication protocol**
- **Introduction of representatives from CALBHBC- California Association of Local Behavioral Health Boards and Commissions**
- **AOT (Assisted Outpatient Treatment) Workgroup will start June 12, From 10am to noon, at 50 Douglas Drive in Martinez in the 2nd floor conference room**

III. **Public Comments- (3 minutes per speaker)**

IV. **Commissioner's comments-**

V. **APPROVE minutes from May 3, 2017 meeting**

VI. **RECEIVE updates from the Director of Behavioral Health, Cynthia Belon**

VII. **RECEIVE presentation regarding injectable protocol- Debra Beckert, RN Nurse Program Manager**

VIII. **RECEIVE updates from the Health, Housing and Homeless Services- Jenny Robbins**

IX. **DISCUSS 2017 Commission retreat/training on September 16, from 10am to 3pm, at 1875 Arnold Drive in Martinez. Materials used for training: 2016 Mental Health Board Manual (attached)**

X. **RECEIVE Commission Representative Reports**

1) AOD Advisory Board – **Sam Yoshioka**
2) CPAW General Meeting – **Lauren Rettagliata**
3) Children's Committee – **Barbara Serwin**
4) Council on Housing Committee – **Lauren Rettagliata**

XI. **Adjourn**

MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
Hosting the Public Hearing,
On the Fiscal Years 2017 to 2020
For the Mental Health Services Act
Three Year Program and Expenditure Plan
May 3, 2017 – First Draft

Agenda Item / Discussion	Action / Follow-Up
I. Call to Order / Introductions The Chair of the Commission, Duane Chapman, called the meeting to order at 4:38pm. Members Present: Chair -Duane Chapman, District I Vice Chair- Barbara Serwin, District II Supv. Candace Andersen, District II Diana MaKieve, District II Gina Swirsding, District I Douglas Dunn, District III (arrived @4:43pm) Meghan Cullen, District V Lauren Rettagliata, District II Mike Ward, District V Commissioners Absent: Sam Yoshioka, District IV Connie Steers, District III Jason Tanseco, District IV Other Attendees: Warren Hayes, MHSA Program Manager of Behavioral Health Adam Down, Behavioral Health Services Admin Jill Ray, Field Rep Supv. Andersen's Office, District II Roberto Roman, Office for Consumer Empowerment Guita Goudarzi, AOD liaison Charles Madison, President of NAMI Sharon Madison, NAMI Kanwarpal Dhaliwal, RYSE Center Organization Kassie Perkins, ANKI BHI Sheri Richards, CPAW Judy Cohen, NAMI Mark Cohen, NAMI Kristen Clapton, CCBH Teresa Pasquini, Family member Robert Thigpen, CCBH Anne Sutherland, AOD Chair Don Green, NAMI PG- Soto Barbara Scott, NAMI Kay Derrico, NAMI	**EA-Transfer recording to computer**

	Melinda Mehan, CCBH Liza A. Molina-Huntley, Executive Assistant for MHC ****The attendees had the privilege to hear Mr. Roberto Roman singing at the beginning of the meeting. All in attendance enjoyed his talented voice.**	
II.	**Proclamation to declare May as Mental Health Awareness Month** • **Supervisor Candace Andersen –** summarized the Proclamation stated that it was passed on May 2, at the Board of Supervisor's meeting. All the Board of Supervisors have signed the proclamation and had great things to say about the Mental Health Commission. Her remarks focused on how important it is that we continue to work to destigmatize mental health. Everyone has been touched by someone who has had challenges due to mental illness. We need to continue to advocate improving the lives of those who suffer with mental illness. Provided and presented the official proclamation, on behalf of the Board of Supervisors. Thank you to everyone for all that you do.	
III.	**CREATE an ad hoc committee to screen Mental Health Commission applicants, to forward to the Board of Supervisors for approval and appointment.** • **Duane-** referred discussion to Supervisor Andersen due to some concerns. We need to remember that the Board of Supervisors appoints our member that is the first step is. The next step should be, but our Bylaws say something different than the Contra Costa Advisory Body Handbook does. I will let Supervisor Andersen take over from here. • **Supervisor Andersen-** We are in the process of making a brochure, kudos to Liza who made a really nice brochure about the Mental Health Commission. Supervisor Mitchoff did express yesterday that her concern, which she expressed previously, about her desire to appoint Mental Health Commissioners before anyone else talks to them or screened. She doesn't like that screening process. What she would like to do is to have Supervisors appoint whoever they want to, as long as the person meets the required statutory requirements of being a consumer, a family member or at large. Then any interaction with the rest of the Commission would take place after that point	• **The Board of Supervisors will meet and appoint applicants interested in becoming new Commission members** • **The Bylaws will be modified to mirror the Contra Costa Advisory Handbook regarding applicants processing**

through an orientation with the Chair or the Committee members. In the past, we have been doing that at times, we haven't always had someone from the Commission reviewing them first. It is a really important thing to Supervisor Mitchoff so we will be bringing that to the Mental Health Commission, a revision of the Bylaws and to the Board of Supervisors that would change that process to mirror the Advisory Board Handbook. The Supervisor would appoint someone and then after that they can interaction would take place with the Commissioners.

- **Gina-** When I am out in my district and I see somebody, I can approach a person with the brochure. I am in the district with Supervisor John Gioia. Why I am saying that is because I talk to a lot of people and tell them about our commitment. The first thing that they ask is: are the meetings in West County? Because it is hard for everyone to come out, a lot of people have transportation issues.
- **Supervisor Andersen-** This brochure will be very helpful and we want you recruiting members, if you have a vacant seat. Let's let it go through the Supervisor and let them make that decision and then they will meet the Commission afterwards. Please continue recruiting. What Karen was concerned about was a formal recommendation by the Mental Health Commission; she just wants to make that decision, then following that decision the interaction with the Commission.
- **Barbara-** I'm just curious on what her perspective is and what commandeer that she wants that?
- **Supervisor Andersen-** The perspective is that, she is ultimately making the appointment, she wants to make that decision and would rather have potential Commissioners sit in on a Commission meeting and then come talk to me about it and hear about their thoughts regarding the role of a Commissioner. She wants her own independent decision; she doesn't want people to tell her if that person should be on the board. She expressed a strong preference for her making the decision; an appointment can take place and then have an orientation follow up. Historically, we have done the appointment and an orientation done post appointment, with the Chair or an ad hoc committee that explains the full details regarding what the Commission does

and what their roles are. Talking to the person, we never had anyone rejected because of it. For that reason, in reference to Supervisor Mitchoff and then the other possibility would be to send the whole thing to internal operations and have a drag out discussion.

- **Diana-** I think one of the biggest concerns that I have about that is that the Supervisor feels to have somebody placed on the Commission is to have somebody in front of their face. We, on the Commission, are very aware of the fact that we are down five Commissioners right now and that makes it difficult for us to do our job. So if we can't get out there and try to find people and recruit, it makes it harder on us.
- **Supervisor Andersen-** Yes you can, with this process in no way do we stop you from recruiting. I think that Supervisor's Mitchoff's concern is having a practice where when someone applies they have to go before an ad hoc committee for a recommendation, as well as meeting her. She did not think that having an ad hoc committee helps.
- **Diana-** So does that mean that we don't have a role or voice in whom comes on to the Commission?
- **Supervisor Andersen**- in a nice way, no. It is her decision on who she appoints for her district and she wants to have the first interface that person has that's going to operate in the role as a Commissioner. That in no way limits Commissioners from going out and recruiting and stating what district openings there are and having that conversation and refer them to their District office.
- **Doug-** In my experience, my name was discussed at the Commission and was issued and appointed by my district supervisor.
- **Lauren-** the procedure was, when I was Chair, was that people could apply through their Supervisor's office or contacting through the Executive Assistance or directly through the CAO's office, they could send an application. The applications were received and our Executive Assistant would verify if they lived in the county and what district they lived in. Then we would interview these people. When I went to my interview there was another gentleman that was also interviewing for the same position and I was interviewed by the whole Commission. I was fortunate that I was picked in the interview. California State law does not

state or outline the exact procedure of the appointment.

- **Teresa-** So this is nothing new that I'm hearing here in terms that there's always been some Supervisor's that feel very strongly about this, it's not only Supervisor Mitchoff that has this strong feeling, I believe John Gioia also has that feeling, maybe not as much now as he did at one time. I think that it's unfortunate the Supervisor has the right to self-appoint and direct appoint. I was direct appointed, as Doug just said. I can tell you that I wished that that wouldn't have happened to me that was a very uncomfortable position for me to be in. I actually came into a room; I believe Diane is here, I believe she was the Vice Chair at the time when I appointed. I came into a room full of people that didn't know who I was, and it wasn't friendly, quite frankly, so I think that it's too bad that there can't be some kind of middle ground here? I think absolutely Supervisor Mitchoff is correct, that it is ultimately her decision and that there has always been that power struggle going back and forth. Ultimately you want to make sure that you have public volunteers that feel comfortable coming to a table with people and know what there is, there should be more interchange.
- **Supervisor Andersen-** and that is where I'm hoping with this whole change in Bylaws, that we can have, when someone is appointed that this when we can focus on the orientation, and inform of the duties and responsibilities as a Mental Health Commissioners, this is how they operate, here's an introduction to the subcommittees and their vacancies and coming and sitting in on a meeting before being on the commission.
- **Gina**- like Teresa, I also did feel a little bit out of place. I think one thing that is nice about it, if we tell them what's expected and we let them ask questions and we shared our experience. A lot of it is getting to know each other.
- **Barbara-** Just a couple of things, in terms of that interview process, that ability to interact with the Commissioners was really important, in my experience. I also feel that it shows transparency and that's important. When the application is put out there, it's for a Committee to review.
- **Teresa-** I think it's been almost two years that I was on this Commission and my seat is still

	vacant, which is absolutely inexcusable! I am making a public statement to the Commission, as a former Commissioner, that it deeply offends me that such an important position, there has been a lot of community uproar in West County and there is no representative for people, other than Duane and Gina, and I'm still getting phone calls, and so. So I'm happy to say that to John Gioia and I'm happy to say it to anybody, but my point is that if you're going to amend the Bylaws and ask that these direct appointments from the Board, then they need to make sure that happens. • **Supervisor Andersen-** They absolutely do. I agree 100% and I don't want any of this to stop anyone's desire to be out in the community recruiting people. • **Duane**- so this is what we're going to do- everything is on hold for right now, except we are still going to go out there and recruit people. Keep recruiting. I am going to check with the California Association of local Behavioral Health Boards and Committees and see how other people are doing it and get some support from them and CAL OSHA, and get some support from them and directions from them, in writing, and that way we will then meet with the Supervisor and let her know what we have come across and see if we can come to a happy medium. I think that's the best way to do it. • **Supervisor Andersen-** I am going to weigh in on this and I am going to peacefully find the least objection that we can still accomplish what we want to do which is to get new Commissioners oriented to the norms of this Commission and get them excited about being here. • **Duane-** do we need a vote on this? No, we are leaving it as is.	
IV.	**RECEIVE introduction to 1420 Willow Pass renovation and CREATE an ad hoc committee for continuing review of the project by Adam Down.** • **Duane-** This is a new project that there was some discussion about and Adam will inform the rest of the board. • **Adam-** Thank you for putting this in a crowded meeting agenda. I often work for the Commission and one of my other roles is that I also work on facilities with the department. Many of you have visited or	**The ad hoc committee will meet with Adam Down, and or Behavioral Health Administration staff, regarding the updates for the renovation to 1420 Willow Pass in Concord. The Commissioners Gina, Lauren and Meghan are the ad hoc committee members and Mike Ward will serve as an alternate.**

	worked or done something at the 1420 Willow Pass clinic, which is a centered Concord adult's mental health clinic. It can use some work, I think anyone who has visited would agree with that statement. There is an opportunity to improve it, the vocational unit had been downstairs, and it was vacated three years ago. The main area upstairs, on the second floor has been continued to be filled with staff members and clients, it's a very busy clinic and creates an environment that is less than welcoming. We feel like we can accomplish quite a bit with some renovations there and expanding, decompressing staff, into that lower level unit. The process of where we're at right now, we engaged the general service department, professional services, consultation and project feasibility early on. We worked with the employees on site, cross section employees, we had nurses, doctors, clinicians, management and a clerk, everybody sat around and asked- what can we do here to make this better for you? We really zeroed in on a few things, the very important we heard them from Commissioners as they've gone and you can see it when you just walk in yourself. The preliminary design that we put forward for approval- to increase lobby, patient waiting area size, decompression of various staff members in the clinic, improved clerical work function, better patient circulation, additional treatment rooms, and a creation of a welcoming environment, including removing the Sheriff's station that is front and center as you walk in the door. We know that it was important to many people. What I hear today, we are looking at about $980,000 in total budget. Of that, $700,000 is construction costs, approximately. What was proposed to the Executive Board, and forwarded to this meeting, was to get an ad hoc committee, assign a smaller number of people that we would like to work, as we move forward, to ensure that the public process has been followed, that you are able to accurately advise and inform the	

Board and the Mental Health Director and your aware of the project as we promised. With that I would like to turn it over to you for any questions or to appoint an ad hoc committee that I will work with going forward to keep bouncing the ideas and report back to the Commission at future meetings. • **Lauren-** As some of my fellow Commissioners may not be aware that my day work is that I have commercial properties and that I am required, as an owner of commercial properties to work with some of my leaser's to do renovations'. The one thing that I wanted to point out to our Supervisor Andersen is that the County does not own this building and putting in $980,000 into a building that we do not own maybe warranted but I know that when I have leasers' come to me when they have to do renovations there is usually an agreement worked out because leasers are very concerned that they can put massive renovations and then only have like a three to five year lease. Usually you then negotiate a longer term lease that incorporates the amount of money that the leaser is putting into the building. Also, every time I go into negotiations with the leasers, if flooring, walking and carpeting are in deteriorating conditions, such as they are at the 1420 Willow Pass property, the owner of the property, usually finances the funds of this type of renovation. I am pretty familiar with renovations and what it takes negotiate them. It does seem like a lot of money but I haven't done one in the last five years in California. I would ask the Supervisors since this is a lot of money, every dollar that we spend on renovations can possibly be used for care. I understand that this is coming out of the general fund. • **Supervisor Andersen**- Do you know the term of the lease that there is on that building? (Adam) • **Adam-** I believe we are in there right now until 2020? Public Works Real Estate is engaged in this project as well.	

• **Supervisor Andersen-** I know we have a pretty good real estate department and let me share some of this with you- the reality is that many of our federal and state programs, we will be reimbursed for lease payments, we will not be reimbursed for a building that we own. So it has been beneficial for us to lease and rent buildings, rather than own them, because then we wouldn't have the reimbursement funds. It is also much cheaper for us to contract, with an outside building with a property management company because they then maintain the building, the provide custodial services and using our own public works labor, to maintain custodial staff is really very expensive when you add all the county benefits. It's generally much more cost effective to lease a building, for its intended purpose but we do have real estate professionals who manage the county's leases and do work out details like getting credit for the property improvements and lease terms. I don't want anyone to think that no is watching the store and we are just throwing money out here. • **Lauren-** I had significant questions because on the Oak Grove property that the County did purchase, it seems like sometimes the County isn't making the wisest decisions when it comes to real estate decisions that they make that deal with mental health. • **Supervisor Andersen-** that's pretty hard if you are going to another location on Oak Grove • **Lauren-** this is a good location, I am just asking that we really do, do due diligence with public works or whoever is negotiating. Because the building, if they are supposed to be maintaining that building for you? I know that at one time Public Works came in to clean the carpets, the building has been in a very deteriorated state, always has been for the last four years and it's not what I would consider a public building at all. That is my two cents and I just want the very best for the people.	

- **Adam-** We are hoping that the ad hoc committee will have a real understanding and we will present this to them. We haven't engaged that far, we have merely scoped out a proposal, that at this point it's still preliminary. That information will be forthcoming, that is the point of forming the ad hoc committee so we can continue to work and make sure that your concerns are met and others concerns are met.
- **Gina-** It's really interesting because in West County they built a new clinic, which is beautiful, it's only medical and the mental health section is at a whole other place. I have visited the Concord clinic, what I like about is that it has the medical part is connected so patients are able to get all the help right there. Where in West County, it's not connected and they have to go to two different places, it's hard to get to and not easy if your handicapped or in a wheelchair. One of the major problems in West County is for consumers to get their lab work done, it's very difficult for them due to transportation and they are on a limited income and have to go to two places. I think it's great that it's combined in Concord.
- **Lauren-** West County is opening up space there.
- **Gina-** yes, that's in process, I know that.
- **Duane-** With that being said, I am going to ask for volunteers from the Commission, to be on the ad hoc committee. Who wants to volunteer for it? Lauren, ok, Gina ok, anyone else, public?
- **Adam-** I would like to propose one of the new Commission members- Michael or Meghan, this a meeting that I can be flexible around your schedules. It does not have to be a set meeting; we can work around and make it work for the people who are involved, if that's ok?
- **Duane-** ok so far I have Gina and Lauren and Meghan, if Meghan cannot make a meeting, then Michael will attend as an alternate.

	• **Adam-** we will be flexible around your schedule (Meghan) • **Duane-** Then that is that, thank you very much for volunteering	
V.	**APPROVE minutes from April 5, 2017 meeting Motion to approve the minutes was made by Gina, Doug seconded the motion** • **No corrections required** • **VOTE: 9-0-0** • **YAYS: Supervisor Andersen, Duane, Barbara, Gina, Diana, Doug, Lauren, Mike and Meghan** • **NAYS: none ABSTAIN: none** • **ABSENT: Sam, Connie, Jason**	
VI.	***Duane adjourned the Mental Health Commission meeting at 5:21 pm in the memory of the Behavioral Health Director's father who just passed, Vernon Belon and also in the memory of a young man, who committed suicide, because of the two people we share in a moment of silence.***	
I.	**The Chair, called to order- The Public Hearing on the Mental Health Services Act Three Year Program and Expenditure Plan at 5:22 pm**	
II.	**Opening Comments by the Mental Health Commission Chair- Duane Chapman.** • Everyone can read, so I am moving on and we will allow three minutes time for each speaker. We are here are to confirm and complete the process. Warren, can you start the process?	
III.	**Fiscal Years 2017 to 2020 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan- by Warren Hayes, MHSA Program Manager** • **Warren-** First of all, I would like to thank the Commission for putting in a big chunk of their time to host the public hearing which is required by statue and regulations and I believe they are listed here. It has been my privilege to provide support for the stakeholder process that started last summer when our consolidated planning advisory work group did the planning and were the helping hands for our community forums that were held in October, November and December. Those were	

	designed to solicit in several venues interactive dialogue around the needs and priorities for the County regarding mental health. In January and February the information was reviewed, that we got from the community forums as well as to review a quantitative needs assessment that looked at Behavioral Health needs from a little different lens. In March we held a joint meeting, the Consolidated Advisory Planning Workgroup (CPAW) and the Mental Health Commission members were invited to have an informal discussion regarding the draft of the Three Year Program and Expenditure Plan. Then we got into the formal part of the process, whereby we posted the draft on the website, changes were made as a result of the informal discussions with CPAW and the Mental Health Commission members. We then posted the corrected draft, for a public comment period of 30 days. That is required also by law. The Commission then hosts, this event, which is a public hearing, which is a formal event. As much as I would love to get into discussions and dialogue about the three year plan, this event this evening is really for the public to provide comment, as well as the Commission members to provide comment and then have the comments listed from both the public and Commissioners, as it is listed on the agenda. We are in the formal period, which means that if you sent me an email asking why we are doing something, at this point we will discuss it, give me a call. A lot of you take advantage of that and I very much enjoy those discussions, they are off the record but they are really important because this is not a simple process. The Mental Health Services Act (MHSA) dollars have lot of strings attached and I am happy to explain to those who would like a deeper knowledge of how these things come together. This process is all in preparation of the plan. After this evening, we will then provide a formal written response to the public comments that came in the 30 day	

	period, the public comments tonight, as well as the Commission's comments and any potential recommendations. That will all go into the three year plan and soon as we get a response to those and get it approved by my boss, the Behavioral Health Director, we will send it to the County's Administrator's Office for putting the plan on the agenda, for the Board of Supervisors. We hope to have this before the Board of Supervisor's for their consideration, sometime in June, so that hopefully we have a plan in place starting July 1, which is the start of the three year period. • **Duane-** ok, with that I am first going to ask for public comments, regarding the plan. • **Warren-** Duane, one last thing here is there is a two page public hearing presentation, that's in your materials. I had put this together as a two page summary that is in your packet. I can read that into the record if you'd like, the last three years I have read the summary so it shows up in the minutes. • **Supervisor Andersen-** I don't know why you need to read it into the agenda to have it part of the minutes? We can hand it over to Melinda and have it be made part of the minutes, unless you really want to read the whole thing in? • **Warren-** No, this is really up to the Commission folks. • **Supervisor Andersen-** I have read it, has everyone on the Commission read it? I'd hate to have you recite it unnecessarily. • **Warren-** I think your points well taken. Right after the draft minutes, which were just approved, which is page six, then the next page is Adam's report on Willow Pass, but after that is the two page summary. If you have not read it you might want to take a look at while there's public comment? • **Duane-** Yes, let's start the public comment	
IV.	**Public Comment regarding the Plan- (Transcribed by Melinda Mehan @47:12 on the audio recording)** • **Duane-** I will start first by calling Mr. Charles Madison. Please everyone speak loud	

enough so we can get it on the recording. Thank you.

- **Charles Madison-** I want to first thank Warren and his group for finally getting a 3-Year Plan together that is readable. For so many years, you had to hunt all over the document to find out what area you were dealing with, and so now we have a program where you can actually look at something. My hat's off to you. Thank you so much for getting that into the program. Secondly, I want to thank the County and I want to thank CPAW for recognizing and adding families into this. I'm speaking as a family member here, and that we are so happy to see that there is an allocation to support families in the 3-year program, and that's pretty much what I've got to say, so thank you very much, everybody, and thank you, Warren.
- **Mary Ann Andrews**- First, I would like to thank the County, CPAW, and all others concerned that a program to support families has been shown in the budget. It's very important to have families supported through these programs for the health and wellness of their loved ones. I understand family members can be tossed around by the whirlwind that is mental health. These programs help educate families to become aware of how to handle and understand their loved ones. It cannot be easy to have a loved one with mental illness, and how to deal with the effects are not always obvious. When do I call to have my loved one hospitalized, and did I do the right thing? Why these suicide cries? What is real, and what is not real? These struggles and so many more can be overwhelming at best. It is important for family members to know that they are not alone as they struggle with the devastation that mental illness can leave behind. To help them to try to understand something that is sometimes not understandable is no easy task, but with these funds, this task can be started. I know that these funds will go to promote awareness and compassionate

understanding of mental illness as a real disease; so again, I would like to thank you for your support of family members. • **Sharon Madison**- I am piggy-backing off of the people who just spoke before me, that I definitely want to express this to everybody, and I really want to acknowledge that the Mental Health Commission, our County, our supervisors, and their recognition of the vital role that families do play in the mental health treatment plans for our loved ones. We've been waiting for this for a long, long time. For some reason, we've been put out in the field like we weren't part of this, and when we look at all these treatment plans and programs and whatever, it becomes quite evident that a lot of the burden of these illnesses falls on the family. So I know I have said this before, but I do want to reiterate this, that I feel that what better gift we can give someone who is living with a mental illness than an educated family. Thank you. • **Anne Sutherland-** Thank you for taking my comments and questions. I am a local physician. I was appointed as a member-at-large on the Alcohol and Other Drugs Advisory Committee and was immediately elected chairman, so I'm new at this. I'm trying to educate myself. I originally wanted to be of service. So please educate me. I read through as much of this as I could, and just as mental health has been marginalized in the community, I'm getting the impression that substance use disorders are marginalized within the mental health community. Please prove me wrong. I looked through this, and I did not see any services specifically allocated for substance use disorders. We have two full-time paid staff members and a lot of volunteers, and other than that, my impression is that we don't have much in the way of funds allocated. My simplest question is, is anything going to be done about getting rid of alcohol and drugs in homeless shelters, because people with substance use	

disorders go through rehab; it's an expensive process, a lot of them don't have homes to go back to; their families end up getting wrecked by their disease, and when they go back to homeless shelters, it's my understanding that a lot of these are called "wet"; there are drugs and alcohol in the homeless shelters, and it ends up being a revolving door for these people. The time and money that were spent on them is wasted, because they relapse.
The second part of my question is that substance use disorders are now considered to be a mental disability. What's being done to integrate them into the mental health services at large?

- **Kanwarpal Dhaliwal**- Good evening; I'm with the RYSE Center in Richmond. This is the first time I've been to a Commission meeting. It's good to be here. I've attended CPAW meetings. Also, I want to echo the suggestion/request to maybe also move meetings around to different regions of the County. It is not easy to get here, and for those of us working in other regions, to be coming to Central County 2-3 times a week is actually pretty challenging. I would just ask that consideration.
What I want to talk about is a few things. One is just the appreciation of the work, the struggle, the healthy struggle. Sometimes it doesn't feel healthy. It really is sort of figuring out how do we ensure that the most structurally vulnerable communities get what we need and what we deserve. And I know that it is no simple feat to do, and I just want to appreciate that work. And in that spirit, I also offer one of the things that we think is really important to start to look at is the sense and idea of atmosphere of trauma, atmosphere of distress. Our young people in our communities talk all the time everywhere they go that they feel threatened, whether it's the system, whether it's going into Target, whether it's going to City Hall, that fact and there's the stress that's happening all the time. I think we are starting to try to

figure out how to address that more holistically. I really want to offer and hope I can work with any and all of you on, on behalf of RYSE, on behalf of the providers that we work with in West County, is how do we really address this holistically so that all the levels of mental health or the distress actually are addressed more holistically when we see the relationship between all of them. I think that sometimes for us what feels challenging about just looking at episodic or individual. Understanding that what happens in our bodies and our minds and our relationships is also related to the social conditions that we're in, and so we really want to push that, and that the solutions are community-grounded, community-rooted. Yes, we all know there's a lot going on in West County, and there's a lot of challenge, and we really feel like we need our services to come from a place of seeing or being part of humanity and not having to be systematized or put into a system before we get anything. Thank you.

- **Teresa Pasquini-** I actually didn't plan on making a public comment; I came to listen today. But I, too, would like to compliment the Commission and CPAW on the Community Planning process. I have been a part of the planning process for these 3-Year Plans since the inception of the MHSA, and I do see a simpler plan to read and follow. I am also happy to see attention given to the families that the Commission has long advocated for. I'll be curious to see how those plans are implemented and how effective they are. I think it's very important to have family support and education, but it doesn't do us any good to educate on how to navigate a broken system, and I can't emphasize enough how the system is still very broken and fragmented, even though we do have some really wonderful programs in place.
  I did want to share that I had the privilege of attending a Laura's Law court session last week. Somebody I have advocated for over

	12-13 months to get into the program was actually finally found. Even though she had hit our Psych Emergency door and/or 4C door 6-7 times and also hospitalized in Marin General and had been referred, but then lost, she was found. I did have the privilege of attending a court session. She had invited me in. I'm not her family member, so we do have a lot of consumers who need advocates – strong advocates – who do not have family members to support them. Gina, this is sort of for you, because I know how you feel about Laura's Law. So I actually pushed – I was told it's a closed session, and I said, "If a consumer is struggling with going to court and they are afraid of going to court, and they have invited somebody to come with them, can we just ask why somebody couldn't be invited in?" And so I was told I had to go and sit in the hallway, which I did do. The Public Defender did invite me in at the request of the consumer. It is supposed to be a consumer-driven process, and so I would like to encourage – I still haven't seen a meeting come forward about our Laura's Law, but the last time I was here, I requested. I haven't seen a community meeting planned. I am really very strongly interested in seeing some changes and some improvements in our Laura's Law process. Last but not least, housing-housing-housing. Housing and transitional care. You all know the story of my Danny. I believe most of you know the story of my Danny. He is currently in an out-of-county placement, and he is doing amazing, very, very well. And as you know, he's been 5150'd over 50 times in his life. The trauma of that is very serious. He's been sent out of County to locked facilities for most of his adult life. This started at 18; he's going to turn 35 in August. We're hoping for him to be able to come back, but I had a conversation with his conservator today, and I don't feel there's a program available in Contra Costa County that would adequately provide his	

	needs. I didn't see anything in this plan that would support consumers who do not require to be in a locked facility that could come back into our community and transition back and be supported. I would strongly encourage the Commission, CPAW, and the Board to explore new contracts with new providers. There are programs out there like Synergy in Morgan Hill. Synergy is opening another program in Sacramento. We have to start thinking outside of the box for the people who have been in a box or locked up, you know, "out of sight; out of mind," for most of their lives, and that is true trauma. I would just really strongly encourage – I don't know if there's anything in the plan; I didn't see anything. I am happy to see the Oak Grove finally come around; however, I would really like to also comment that that's not something really to celebrate, because that was actually on my agenda 6 years ago. I don't know what's taken so long, so that's a little frustrating as well. So I celebrate the good things and the positive things, but we have a long way to go. Thank you.	
V.	**Commissioner Comments-** • **Duane Chapman-** As a Commissioner, I'm glad to see that we are concentrating on the family. Family means a lot to everybody, and I don't tell everybody a lot that I have 3 people in my family that suffer with their mental health, one died, and I have two others that I take care of. Family is very important; to understand to make sure you're doing the right thing. How many times I've called the police. How many times I have fought with my brothers and sister to do the right thing, and when I read this and saw that there was going to be a lot of attention to family, I said, "Right on." However, we still have a lack and a broken service. Yes, we're not perfect. The County is not perfect. But as a Commissioner, I ask you, and as the Chair of this Commission, if you see something that needs to be paid attention to, stop, write it down, and send it to me. Because if it's in	

writing, it's better than saying it. And then with that, we have something to take to the Board of Supervisors. But you know, people can say anything they want to say. If you don't get up and say it in front of the Board, or you don't put it in writing, guess what? It didn't happen. So I know we have a lot of energy and a lot of concerns, but if you have a problem you think about that young man who committed suicide earlier this month. It took me back, and I want to make sure that as many people as we can save, we do it together. Thank you.

- **Lauren Rettagliata-** I did submit them via writing, and I will leave Melinda a copy. My first comment is, I have a number of comments, I have drilled down, and I am going to drill down into the housing section. Because housing was cited as the number one thing that needs to be addressed at our Community Planning Process by the people who attended; housing and supportive housing. Yet, if you'll note in the vision statement, there is not one thing that is mentioned about providing housing through our mental health services plan. So I would like that to be addressed. I think there needs to be a statement in the vision that we as a community have addressed housing and supportive housing as our number one need. It wasn't just this year; it's been for the last 3 planning meetings I've been at. In the Needs Assessment on page 10 clearly calls and this is the quantitative study that was done by the Mental Health Department, clearly called for improved capacity to assist consumers who move from locked facilities to community based services. Yet this is not addressed in the Plan. It was called out as being much needed. It was called out in the Quantitative Needs Assessment. It was called out at the Community Planning Process meetings. It has been continually called out at Mental Health Commission meetings. There is no provision for this in the 3-Year Plan. The lack of housing and the correct supportive housing was

	identified as the number one need. The $1.7 million funding in the Plan is not new money but old money that was not used. It is designated for permanent housing and not for transitional housing, which is integral to a workable system of care. "No Place Like Home" program funding cannot be used for this essential treatment and care element, so I think we really have to address it, and we cannot wait for the next 3-Year Plan to do this. shelters are listed under housing services. Shelters are not housing. Shelters are emergency services. Shelters need to have their own designation under emergency services. Since MHSA funding is the major source of the shelters, what provision in the County System of Care Plan assures that beds for those with a serious mental illness receive priority? What are we doing to assure that patients from Psych Emergency, Contra Costa Regional Medical Center, 4C, Miller Wellness, and Hope House and Full Service Partnerships have access to this emergency service? MHSA clearly states that the funding is to be directed for the use of those with a serious mental illness – not a mental health condition, not for someone in temporary trauma, but for serious mental illness. This Commission worked diligently for two years to develop a program and fiscal review process. We now have an excellent tool to evaluate every program funded with MHSA funds, that are contracted, and also that are performed by our own county. Of the last seven programs evaluated, all seven were found deficient in effective communication between the contract manager and the contractor. How are we going to remedy this was not addressed in the 3-Year Plan. Almost all of the augmented board and cares had findings that required further attention in quality assurance and staffing sufficient for the program. There were also medication; there were very many deficiencies. So my	

	question is, we should have in this 3-Year Plan, because we knew we had this problem, we should have addressed what are we going to do if we have to shut down an augmented board and care, because this is a real possibility. As you know, I went on some of the facilities. Some of them looked pretty good, but actually there were many recommendations were being made that what was happening was people were being placed out into augmented board and cares and really never heard from again. They were disconnected with their case management. That was noted by Warren's team that went out. So these people may not be using our emergency rooms; they're not really receiving treatment and care, and we may have to shut down some of these augmented board and cares. So my question is I think this 3-Year Plan should address and have money provided for what happens to these people if we do have to go in and shut down an augmented board and care. And my question is, with the tool that we have before us, with the program and fiscal reviews, who is held responsible to see that deficiencies are corrected? Will the contracted agency be allocated the MHSA funding if these deficiencies are not corrected? If we shut down augmented board and cares, where do the residents go? And where is the plan to house these residents if the placement they are currently in is not providing care? Then on page 20, there was an attempt to address housing, and it says, relevant program/planning elements: Sufficient affordable housing for all consumers of Contra Costa Behavioral Health Services is not what MHSA, that these funds cannot really be used, there's no way that we can address the 3,800 homeless residents that we have. But what I'm saying we can't just dismiss that we have 3,800 homeless and say MHSA funding can't address this. MHSA funding is asked to address the housing needs of those who are severely and persistently mentally ill. Where it ends,	

	where we need that critical gap to provide traditional housing for those leaving locked facilities and those who are housed in a full service partnership. In February 2016, full service partners came to a Mental Health Services Act committee meeting and let us know that 10% of those that they serve were homeless. This homelessness was not by choice, I don't believe. I think many times it is because the alternative is an abysmal living situation, many times situated in what we call a drug corridor, many times in room and boards that are bedbug infested, and many times in areas and shelters that are hidden from public view. Supportive housing, on page 38, Shelter Inc. 119 units, $2.281 million. What is used to assure that those who receive one of the 119 units have received a diagnosis of severe mental illness? I know we used the LOCUS and the CALOCUS, but these units are for the severely and persistently mentally ill, so is a physician's assessment required for these people? How do we assure that the people living in these 119 units are severely and persistently mentally ill? Do we do a check every three years, do we do a check every four years, what do we do? We have now have an MHSA plan for at least eight years, yet we have the same conditions getting even worse. We have to ask ourselves, for 8 years we have had MHSA funding for the limited future, and as you know, the Commission wrote the White Paper and we showed that conditions for the severely mentally ill are not improving in this county. So, is what we're doing the right use of the funding? Though intake times have improved for those with a serious mental illness, treatment time and the ability to see a psychiatrist at the clinics has not improved, and I thank Warren and his team for the placing in the Workforce Education and Training (WET), at least it's an attempt to draw psychiatrists into our county.	

What method is used by our county to place MHSA contracts that are more than $250,000 out for re-bid at least every five years? Without having a request for a proposal opportunity every so many years, the County loses the ability to be assured that the best services are being provided by the best contractors. I know that, because I've been reading the plans now for five years, I've never seen anything go out for a re-bid on a request for a proposal. I appreciate the time that everyone has had to take notes on this.

- **Gina Swirsding-** One of the things I'm really glad, looking over the plan, is that because we did have, from my part of the county, they came out to speak on their needs of trauma. Getting help for those, especially those who experience gun violence. I've been talking all throughout the County, mostly with police officers and first responders, paramedics. Because in many aspects of gun violence, the burden is actually a lot on them. And this was my experience, when I got shot at, there is no help. Even though I went to a group, at Herrick Hospital at an outpatient program, and they would never let me talk about it. In my experience with mental health, the reason why I'm mentally ill is because when I got assaulted in 1989, I did not talk, because the person who assaulted me died in the process of it.
  Not only did I get as being the victim, but also got visited by the homicide detectives. In my mind, I was thinking I was going to jail. And I still sometimes believe that, even though it's been so long. I have this fear that I'm going to go to jail because this person died because I defended myself. When you don't talk, you become mentally ill. So, when I got shot at, I started talking, and that's when actually I think it was good. If you don't, what happens is you have revenge, like I did. Why was I like that? Because actually in reality, I was really suicidal. I didn't care. So why I'm saying this is I've been working with a lot of kids in

	my area, and a lot of them are traumatized. They're functioning, they're going to school, but a lot of them are traumatized because of gun violence. I'll ask kids' questions and then you see their little eyes open, and they start talking about what their experience is on the gun shooting they experienced. That's why a lot of our gang members go out and shoot each other. So where did I get the help? Not from the psychiatric community, not from the police department, because they disassociate, not by the military, because they disassociate. I ended up talking to gang members, and that's where I got my help. So I started asking around, where is the building, where I could go if I was a victim of gun violence? I couldn't get help because there is no place. There's a place for people who are sexually assaulted, for people with domestic violence, there's places you could go and say, "Hey, I need help." And they can help you through that process, but when it comes to gun violence, there is no place. I read an article about a woman that her daughter was shot, last year, at the Hilltop Mall. The woman is from Mill Valley and the daughter was too. This mom now is going to Richmond from Mill Valley, trying to find out why her daughter was shot. That is a response that people can have. So I don't know what to do but the reason why I joined this Commission was because of just this matter of gun violence; which occurs in every part of this county. Even in Concord and I've heard about it in all different places. It's increasing. So I just think there needs to be a place for people to go and there needs to be a small group. In a small group, where people who were shot at, can talk together about it. Like people with drug and alcohol, you have people who can relate and you get help that way. That's how I get help for my mental illness, talking to other people who have experienced the same thing. I'm joining the Commission again for another three years and this is one area I really want to be	

	addressed. I know it may not be in this budget but I'm already working with some people in my county. I'd like to see this throughout the county, from East County to Central County and in West County. There are a lot of victims out there and they're alone. But I'm glad, I read some of the stuff in the plan and I like it. So I want to say, you did listen to us. **Supervisor Andersen-** Warren is here to listen and accept the comments **Duane-** So we need to develop a list of comments and a list comments and recommendations to the County Mental Health Administration and to the Board of Supervisors.	
VI.	**Develop a list of Comments and Recommendations to the county mental health Administration (MHA) and to the Board of supervisors (BOS)** **Duane-** I think we've heard everything today and I know that we have Melinda here and we have Liza, who will get all this information back to us as quickly as possible. One of the things as a Commission, we're going to hand-deliver the comments that were said today, to the Board of Supervisors and we will ask them to read them, word by word. **Warren-** Duane, just so you know your statement will be part of the plan. **Gina:** Can a Community member still go to the Board of Supervisors to express some of their needs? **Supv. Andersen:** You always can go to the Board of Supervisors. We're down to 2 minutes, because our meetings are so long. You have 2 minutes to make a public comment. **Gina:** No, before the June thing. **Duane:** Anyone else have anything to say that you think is important enough to give to the Board of Supervisors? You will go first, you have three minutes. **Guita Bahramipour:** Could you please describe on page B34, regarding First Hope and the budget is $1.6 Million. I just want	

to know how they can manage with such a little funding to manage this wonderful program.
Warren: I'd be happy to talk to you in depth about the First Hope program.
Duane: Excuse me, we are not having an open discussion.
Warren: It's an excellent question I'd be happy to chat with you offline in depth about it.
Sheri Richards: I wasn't going to speak; I just wanted to listen and be a fly on the wall, so to speak. I want to say that I've been inspired at this meeting, hearing from AOD, hearing from Gina, that people that are in this Commission and people that volunteer are motivated because they have their own personal stories. For me it's about older adults and I didn't hear that this evening. I wanted that to go on the record. Something that I've said, I think I said it in one of the planning meetings, all the issues of housing, transportation, stigma, discrimination, add old age to that, and the voice for older adults just isn't there. It's my observation. What got me here was just simply curiosity, but it was also coming from a home of being the responsible person, I felt some sense of responsibility to bring back the information to the Older Adult Committee and I'm so glad I came. What is missing is internal advocacy. It would have been really neat if someone in one of the areas said, "Hey, Sheri, this would really be a good meeting for you to go to." Lauren nudged me at CPAW, and I think that was in the back of my mind, maybe this is what she was talking about. So I appreciate any communication, don't hesitate, because new people like myself, I'm learning the ropes, and this doesn't come naturally. People need encouragement to speak up and to voice what they are witness to. Thank you.
Jill: So maybe, Warren, you could just give a little burb on what the deadline is to receive comments on this plan?
Warren: Actually it is. I think Duane

	actually explained it quite nicely just now, which is that Melinda is our scribe. She gets all the comments. We then go into lockdown to sort it all out and officially respond to all the comments, and that then goes into the 3-Year Plan that the Board of Supervisors can see what the public comment period, because that started in March, and so this public hearing tonight actually is the culmination of that. **Jill:** So if anybody has comments on the final plan, go to the Board of Supervisors hearing and make their comments public at the Board of Supervisors, or submit them prior to that meeting? **Warren: Yes** **Supv. Andersen:** If you want a response, you have a few minutes left. **Kanwarpal Dhaliwal:** I would like to see a consideration of the emerging science around chronic stress, chronic trauma across the lifespan, so adverse childhood experiences, all of that. I don't see any of that sort of in it and it's definitely something I think is important and that we have an opportunity to integrate into what we already know. So I'd like to see the chronic trauma, chronic stress, ACEs kind of stuff, trauma-informed approaches be a part of it. I'd also like to really see, for the record, how we are addressing the trauma of racial aggression that plays out in all that we're doing. **Gina Swirsding:** I want to echo what she said. That's what lacks in psychiatry, is how to treat people with PTSD. I was placed on different types of medications because it mimics other things. My psychologist, who is a specialist for PTSD, was constantly fighting on my behalf, to get me off the medication that made me worse. I couldn't sit and watch my favorite TV shows because PTSD mimics other mental illnesses so I was given the wrong medication which made me very aggressive. Being placed on the wrong medication can make a person more aggressive or even suicidal. When my psychiatrist, who worked at the Veterans	

Administration, fought for me to be finally taken off the wrong meds, I got better. There are a lot of medications and psychiatrists and they all handle trauma differently. It's about finding the right doctor, to prescribe the right medication. They need to know how to handle people that have been through trauma. Especially if a person is older and taking other medications, due to other health problems, this is something that does need to be evaluated. **Duane-** Alright, with that, on behalf of the Commission, any other comments? The only thing that I am going to ask everybody else to do is to make sure that you get one of these brochures. Especially all of you that came to visit today, become a Commissioner, and come have some fun. Like I so love, it's not a ten hour job, ok. If there is nothing further and we are all in agreement? **Commissioners-** Yes! **Duane-** Then I call this meeting to end.	
VII. Public Hearing was adjourned at 6:20 pm	

Respectfully submitted,
Liza Molina-Huntley
Executive Assistant to the Mental Health Commission
CCHS Behavioral Health Administration

MANUAL
FOR
LOCAL MENTAL HEALTH BOARDS AND COMMISSIONS

MAY 2015

Revised January 2016

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SECTION 1

WHAT ARE THE DUTIES OF MENTAL HEALTH BOARDS?

Local mental health boards are established in the **California Welfare and Institutions Code (WIC) 5604(a)(1) et seq.** *The specific regulations are included in the manual as Appendix A, B, and C.*

The mental health board may be established as an advisory board or a commission based on the preference of the county.

Local mental health advisory boards must comply with WIC Sections 54950-54963, the Ralph M. Brown Act (Brown Act).

WIC describes the composition of the mental health board:

- Each community mental health service shall have a mental health board.
- The membership is appointed by the Board of Supervisors, but the local mental health board can make recommendations to the Board of Supervisors.
- Appointees should be individuals with experience and knowledge of the mental health system and reflect the ethnic diversity of the client population in the county.
- Each member of the board is appointed for three years, and those appointments can be staggered so that about one-third of the appointments expire in each year.
- With the exception of consumers*, no member shall be an employee of a county mental health service, the State Department of Health Care Services, or an employee or paid member of the governing body of a mental health contract agency. **Consumers who work for the above-named agencies may be appointed to the board if they hold a position in which they do not have any interest, influence or authority over any financial or contractual matter concerning the employer.*

Revised by CALBHB/C April 2017

- Members of the board must abstain from voting on any issue in which the member has a financial interest
- In counties with a population of over 80,000, the board will consist of 10-15 members, but may be more if the governing board wishes:
    - 50% of the membership shall be consumers or the parents, spouses, siblings or adult children of consumers who are or have been receiving mental health services;
    - At least 20% of the total membership shall be consumers;
    - At least 20% of the total membership shall be families of consumers.
- In counties with a population of fewer than 80,000 the board will consist of at least 5 members:
    - At least one member shall be a parent, spouse, sibling or adult child of a consumer who is or has been receiving mental health services.

WIC describes the duties of the mental health board:

- Review and evaluate the community's mental health needs, services, facilities, and special problems;
- Review any county agreements entered into pursuant to Section 5650 (*specifically to assure that the local mental health advisory board has reviewed and approved procedures ensuring citizen and professional involvement in all stages of the planning process*);
- Advise the governing body and the local mental health director as to any aspect of the local mental health programs;
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process;
- Submit an annual report to the governing body on the needs and performance of the county's mental health system.
- Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.
- Review and comment on the county's performance outcome data and communicate its findings to the California Mental health Planning Council
- Assess the impact of realignment of services from the state to the county on services delivered to clients and on the local community.
- Perform any additional duties or authority as assigned by the governing board.

WIC describes reimbursement to the members of the local mental health board:

- The Board of Supervisors may pay from any available funds the actual and necessary expenses of the members of the local mental health board incurred as part of the performance of their official duties and functions.
- The expenses may include travel, lodging, child care and meals as approved by the director of the local mental health program.

WIC describes the by-laws of local mental health board which must include:

- The specific number of individuals on the mental health board, consistent with the regulations.
- The composition of the mental health board to ensure representation of the county demographics.
- The quorum as one person more than one-half of the appointed members.
- The consultation between the chair of the mental health board and the local mental health director.
- The possibility of having an executive committee.

COUNTY HEALTH SERVICES

In California, counties have been providing health care services for almost 150 years. With the exception of local Health Departments operated by the cities of Berkeley, Long Beach, and Pasadena, counties provide a wide variety of health services to all residents of the county, regardless of whether they reside in the unincorporated area or reside within city limits. In other words, the county Health Department is also the cities' Health Department. A County Organized Health System (agency or department) is usually administered by an Administrative Director who is appointed by either the County Administrative Officer (CAO) and/or the Board of Supervisors and is responsible to them for all health related issues. The Board also appoints a Public Health Officer (physician) who serves as the chief medical officer for the county on public health issues. The type of organizational structure and programs offered can vary from county to county, as this is one of the most complex and diverse areas of county government and one which affects every county resident.

OFFICE RESPONSIBILITIES

Alcohol-Drug — Assures necessary substance abuse services are available to the public through a network of public operated and private contracted providers. Services typically include inpatient and outpatient care, residential recovery, detoxification, information, education, prevention, and early intervention.

Detention Facilities — Assures that necessary medical, dental, psychiatric, and substance abuse services are provided to adult and juvenile persons incarcerated in county facilities.

Environmental Health — Provides all health related approvals and permits relating to land development (well water permits, septic permits, and land use permits), consumer protection (food facility inspections/permits, public pools, small water systems, solid waste, and foodborne illness investigation), and hazardous materials (underground storage tanks, medical waste, Proposition 65 reporting, chemical spills, and incident response). (See separate description in this section.)

Emergency Medical Services (EMS) — If designated as the local EMS agency, responsibilities involve ambulance permitting and monitoring, Emergency Medical Technician certification, emergency medical dispatch approvals, and disaster planning.

Hospitals — Prior to the implementation of Federal Medicaid in 1964, 49 counties owned and operated 66 general acute care county hospitals. In 1994, 21 counties own and operate 28 county hospitals which serve as safety net providers of last resort to any person seeking medical care. Most of these hospitals are full service teaching hospitals affiliated with university medical schools. Services vary slightly from hospital to hospital but generally include medical, surgical, emergency, trauma, outpatient, and a wide variety of specialty services.

Indigent Medical Care — Provides medical care to indigent persons, including Medically Indigent Adults, in a variety of ways including operating a county hospital and/or primary care clinics, or using a wide variety of contracts with providers of care to fulfill their responsibilities.

Medically Indigent Adults (MIA) — Counties are separated into two categories in fulfilling state mandated medical and dental services to eligible persons. Those counties with a population over 300,000 in 1980 are referred to as Medically Indigent Services Program (MISP) counties and are required to administer their medical program. Those counties with a population under 300,000 in 1980 have an option of either contracting with the state to administer their MIA program as a County Medical Services Program (CMSP) or administering it themselves (MISP county). Most MISP counties are in the process of developing and implementing managed care plans.

Mental Health — Provides a wide range of psychiatric services to the public either directly or by contract with providers. Services typically include acute inpatient care for Welfare and Institutions Code Section 5150 persons (danger to themselves, others, or are gravely disabled), State Mental Hospital placements, long term care in institutes for mental disease, local crisis services, day treatment, outpatient care, and operation of a conditional release program for Penal Code offenders. Starting October 1, 1994, county mental health programs will provide managed care for hospitalized persons.

Public Health — Services include prevention, early intervention, education, and treatment through a wide range of specific programs and services which typically include adult health screening; HIV/AIDS testing and counseling; communicable and infectious disease control; immunizations; family planning; children's services (CHDP, physical exams, medical, nutrition, etc.); sexually transmitted diseases; home nursing visits; tuberculosis; Women, Infants and Children (WIC) nutritional services; and vital statistics registration involving birth/death certificates and burial permits. Normally a public health laboratory is on-site to perform all tests required by the nursing functions of public health in addition to testing for rabies, water, food, lyme disease, parasites, bacteria, and microorganisms.

AB 1234 ETHICS TRAINING: TRAINING FOR LOCAL OFFICIALS

On October 7, 2005, the Governor signed Assembly Bill No. 1234. AB 1234 requires that if a local agency provides any type of compensation, salary, or stipend to, or reimburses the expenses of a member of its 'legislative body' (as that term is defined in California Government Code Section 54952), that local agency's officials must receive training in ethics.

The bill also provides that if an entity develops criteria for the ethics training required by AB 1234, then the Fair Political Practices Commission and the Attorney General shall be consulted regarding any proposed course content. Other than the consultation requirement regarding the training course, the Commission has no jurisdiction to interpret or advise on the requirements of AB 1234. In response to AB 1234's requirement that the Commission be consulted regarding proposed course content, the Commission has implemented Regulation 18371. Please see Regulation 18371 for information on what the Commission has determined should be included in a local ethics training course. A link to Regulation 18371 and the Attorney General's Office's AB 1234 information can be found below.

There are numerous training options, including training conducted by commercial organizations, nonprofits, or even an agency's own legal counsel. In addition, interested parties have collaborated to create an on-line training program that will allow local officials to satisfy the requirements of AB 1234 on a cost-free basis. The training may be accessed by clicking the button below, and at the end of the training a certification of completion must be printed.

http://localethics.fppc.ca.gov/login.aspx
The **free** online training offered here is a self-serve training program. It is your obligation to print a certificate and provide it to your agency in a timely manner. Please allow ample time to ensure that you are able to complete the training by the due date.

See Government Code Section 97103 attached.

SECTION 2

WHAT IS THE MENTAL HEALTH SERVICES ACT?

California voters passed Proposition 63, also known as the Mental health Services Act (MHSA0 in November 2004 to expand and improved public mental health services and establish the Mental Health Services Oversight and Accountability Commission (MHSOAC) to provide oversight, accountability and leadership on issues related to public mental health. MHSA services maintain a commitment to service, support and assistance.

At that time, the California public mental health funding was insufficient to meet the demand for services. County authorities estimated serving about half the population that needed public mental health care. The majority of mental health funding went to the treatment of individuals with the most severe and persistent mental illness, state hospitals and the criminal justice system. For this reason, California's mental health delivery system was frequently portrayed as a "fail first" model. Instead of providing services, the "safety net" of an under-funded system had become the criminal justice system the courts, and emergency rooms.

In their March 2003 Report, the California Mental health Planning Council estimated that between 500,000 and 1.7 million Californians needed mental health services but failed to receive care. In addition, cultural, racial and ethnic populations have been disproportionally affected because they use fewer mental health services. Child under 18 years of age, for whom early diagnosis and treatment are critical, have been especially underserved. It is estimated that 75-80 percent of all children requiring mental health services were not receiving them.

The California voters approved a 1% tax on incomes over $1 million to fund Proposition 63 and more than $8 billion have been raised. Approximately 1500 programs have been developed throughout the state and many thousands of people have been served.

There are five components to Proposition 63:

- Community Services and Supports (CSS) provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are included in CSS and provide wrap-around services or "whatever it takes" services to consumers. Housing is also included in this category.
- Capital Facilities and Technological Needs (CFTN) provides funding for building projects and increasing technological capacity to improve illness services delivery.
- Workforce, Education and Training (WET) provides funding to improve and build the capacity of the mental health workforce.
- Prevention and Early Intervention (PEI) provides an historic investment of 20$ of Proposition 63 funding to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- Innovation (INN) funds and evaluates new approaches that increases access to the unserved and/or underserved communities. It also promotes interagency collaboration and increases the quality of services.

SECTION 3

THE RALPH M. BROWN ACT

The Ralph M. Brown Act, originally a 686 word statute that has grown substantially over the years, was enacted in response to mounting public concerns over informal, undisclosed meetings held by local elected officials. City councils, county boards, and other local government bodies were avoiding public scrutiny by holding secret "workshops" and "study sessions." The Brown Act solely applies to California city and county government agencies, boards, and councils. The comparable Bagley Keene Act mandates open meetings for State government agencies.

By enacting the Ralph M. Brown Act in 1953, the Legislature declared that the public commissions and boards and councils and the other public agencies, in this State exist to aid in the conduct of the people business. It is the intent of the law that their actions be conducted openly. The Brown Act has been substantially expanded through the years in order to address a variety of issues. It is important to refer to the most recent copy of the Brown Act to assure current information.

The people of this State do not yield their sovereignty to the agencies, which serve them. The people, in delegating authority, do not give their public servants the right to decide what is good for the people to know and what is not good for them to know. The people insist on remaining informed so that they may retain control over the instruments they have created. Ralph M. Brown Act

Does the local mental health board need to comply with the Brown Act?
WIC 5604.1 clearly states: *Local mental health advisory boards shall be subject to the provisions of Chapter 9 commencing with Section 54590 of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.*

What constitutes a meeting?
A meeting is any congregation of a **majority of the board members** of the group to hear, **discuss or deliberate on an item that is within the subject matter jurisdiction of the group**. Meetings may include briefings, hearings, committee meetings, and board retreats.

All meetings must be held within the jurisdiction of the legislative body. There must be a set time and place for regular meetings; special meetings and emergency meetings are allowed at other times and places. Meetings that must comply with the Brown Act include:

- Board meetings: a majority of members are in the same time and place to hear, discuss or deliberate on any matter within the board's jurisdiction.
- Telephone or other electronic device: a majority of members communicate directly on the subject matter of the body.
- Standing committees: members address a continuing subject matter and meet according to a schedule

- Retreats: a majority of members are in the same time and place to hear, discuss or deliberate on any matter within the board's jurisdiction.

Meetings that are not covered by the Brown Act include:

- Ad hoc committees: meetings that are advisory and consist only of less than a quorum of members
- Conferences or workshops: if a quorum of the board is present members should not discuss, deliberate or act upon subject matter pertinent to the board
- Individual conversations with any other person
- Notice meetings of other boards: if a quorum of the board is present members should not discuss, deliberate or act upon subject matter pertinent to the board
- Social or ceremonial occasions: if a quorum of the board is present members should not discuss, deliberate or act upon subject matter pertinent to the board

What is a "special" meeting?

Special meetings are designed to allow boards to deliberate and/or act prior to the next regular board meeting. They often take place in order to meet time deadlines. So long as the president or majority of the board calls the meeting, proper notice is given and the agenda is posted in a timely manner, a special meeting is proper.

A special meeting is called when a body needs to:

- Discuss or act on a matter that it deems pressing enough not to wait for a regular meeting
- Convene at some place other than it's adopted meeting site
- Departs from its regular calendar and meets at some other time or place.

A special meeting requires notice be posted at least 24 hours prior to the meeting in locations that are freely accessible to members of the public during the **entire** 24 hours. No business other than the business posted on the agenda can be considered.

What is an "emergency" meeting?

Emergency meetings of the board may be held under circumstances where certain situations arise that require prompt action due to the disruption or threatened disruption of public facilities:

- An emergency is a work stoppage, crippling activity or other activity that severely impairs public health or safety as determined by a majority of the members of the board
- A dire emergency is a crippling disaster, mass destruction, terrorist act, or threatened terrorist activity that poses immediate and significant peril.

1. Emergency meetings may be held by the board without complying with posting requirements. The presiding officer must give newspapers/radio/television stations that have requesting writing notice of special meetings a one-hour notice by telephone if the telephones are operating. If the telephones are not working, notice must be given to the media that the emergency meeting was held, the purpose of the meeting and the action taken during the meeting as soon as possible after the meeting. The minutes must be

posted as soon as possible following the meeting and include a list of board members present and any action taken.

Where can a meeting be held?
Meetings must be held within the jurisdiction of the board with a few unique exceptions. All meeting sites must be accessible to any member of the public.

Video conferencing of meetings and broadcasting of meetings is permitted and must allow participants at other locations to have both the ability to see what is happening at the main meeting place and to participate by way of some form of telephone or other communication device.

No member of the public may be required to register his/her name or provide any other information, to complete a questionnaire or to fulfill any condition precedent to attendance. Any sign-in sheet, attendance list, or other similar document must state that signing it is voluntary and not a condition of attendance and that all persons may attend the meeting regardless of whether they sign, register or complete the document.

Anyone attending an open meeting of a legislative body may record it with an audio or videotape recorder or still or motion picture camera unless the board makes a reasonable finding that noise, illumination or obstruction of view will disrupt the meeting.

How are meetings noticed to the public?
Agendas for regular meetings must be posted at least 72 hours before the meeting in a location freely accessible to members of the public. The agenda must specify the time and location of the regular meeting.

- The agenda must provide a "brief general description" of the items to be covered including items to be discussed in closed session. This description does not need to be longer than 20 words but must describe the agenda item adequately for a member of the public to determine his/her interest.
- The agenda must be posted in a location "freely accessible". The location must be a place where it can be read by the public at any time during the 72 hours immediately preceding the meeting. Weekend hours may be included as part of the 72 hours.
- Where teleconferencing is used, the agenda must be posted at each teleconference location.
- The agenda must include information regarding how, to whom, and when requests for disability-related modifications or accommodations, including auxiliary aids or services, may be made by persons with disabilities requiring the accommodation.
- Members of the public may request copies of the agenda or copies of all of the materials constituting the agenda packet be mailed to him/her. The materials shall be mailed at the time the agenda is posted or upon distribution of the agenda to a majority of the board, whichever occurs first. Requests for the agenda must be in writing and must be renewed annually following January 1 of each year.

Items that are not included on the posted agenda generally cannot be discussed by the body. The exceptions include:

- A majority vote of the board that an "emergency situation " exists
- A determination by two-thirds vote of the board present (or a unanimous vote if less that two-thirds of the board are present) that there is a need to take immediate action OR that the need for action occurred after the agenda was posted.
- The item was posted on a meeting agenda at a prior meeting less than five calendar days prior to the current meeting and is being continued.

What rights does the public have to view and get copies of documents?
Agendas and other documents distributed to the body must be available to the public at the same meeting without delay.

Members of the public may request copies of the agenda or copies of all of the materials constituting the agenda packet be mailed to him/her prior to the meeting. The materials shall be mailed at the time the agenda is posted or upon distribution of the agenda to a majority of the board, whichever occurs first. Requests for the agenda must be in writing and must be renewed annually following January 1 of each year.

Does the public have the right to address the body?
The public may address members of the body on matters on or off the agenda. The public also has the right to preserve the proceedings by photography or electronic recording and even broadcast them to the community.

The body can set time limits on this input, including total time and limits for each individual speaker. A typical definition of "reasonable" is 3 minutes per person. Public comment may be held at the beginning of the meeting or end of the meeting. It is typical for the public comment to be held at the beginning of the meeting.

The First Amendment does not allow the body to limit public comment because it is offensive. A body cannot prohibit public criticism of the policies, procedures, programs or services of the agency. The body also cannot prohibit public criticism of their actions or omissions.

There is limited authority for a board to act on non-agendized business at regular meetings; no business which is not specifically included in the agenda may be considered in a special meeting. Generally the body will hear public comment without any response except perhaps for clarifying questions.

Speakers may also speak to the agenda item when it is discussed by the body. They may also address items on the closed session prior to the time the closed session is held.

What are the rules for a closed session?
A closed session is an exception to the general rule that board meetings must be open and public. The legislature has declared that business affecting the public may be conducted behind closed doors only in narrowly defined circumstances. Closed sessions may be held at regular, special and emergency meetings. The court has held that a board has a right to act upon considered matters in closed session but they are required to publicly report certain actions taken in closed session and the vote of every member present.

Closed sessions may be held to consider:

- Real estate negotiations: a board may meet with its negotiator prior to purchase, sale, exchange or lease of a real property. Before going into closed session, the board must disclose the identity of its negotiators, the property concerned, and the name of the person the negotiator will meet with
- Pending litigation: a board may meet, on advice of counsel, to confer or receive advice from counsel regarding pending litigation.
- Labor negotiations:

Closed sessions are not open to the public or others who do not serve some function essential to the confidential communication.

- Generally no minutes are taken in closed session.
- The body is required to report specific actions taken in closed session when the session is completed.
- The body must report the vote of each individual member if voting occurred during the closed session.
- Any written materials approved as part of the closed session action, for example a contract, must be disclosed upon request following a decision.
- No person may disclose confidential information that has been acquired by being present in a closed session unless the body authorizes the disclosure of that information.

Any type of meeting may be adjourned to a specific time and place as stated in the order of adjournment. Unless a specific time and place are stated in the adjournment, the subsequent meeting must be held according to the bylaws or other rules of the Board

Special meeting may be called by the presiding officer or a majority of the members. Notices must be delivered at least **24 hours** prior to the meeting. Only the business stated on the notice may be discussed. The notice must also be posted in a location that is freely accessible to the general public. Emergency situations involving work stoppage or other activity that may severely impair public health, safety or both can permit an absent meeting notice. Every effort should be made to see that local newspapers, radio and television stations that have requested notification are so informed. As with closed meetings, when a situation requiring an emergency meeting arises, the law should be carefully reviewed and legal counsel consulted.

Any individual attending a public meeting **must be given** all the information that is distributed to all or a majority of the members of the Board. Only those items exempt from public disclosure (such as those covered by patient confidentiality or employee records) may be kept from anyone in attendance. Even those items prepared by some other person must be made available after the meeting. It is possible to charge a fee for copies made available under this section.

The Board **does have the right** to clear the room of people disrupting the orderly conduct of the meeting. Efforts should be made to quell the disturbance by other means before taking this

action. Again, only items on the agenda may be discussed. The press must be allowed to remain, unless they are part of the disturbance.

The punishment for violating the Brown Act is within the misdemeanor range of offenses. In order to prosecute, the Board must have a wrongful intent to deprive the public of information to which it is entitled. If in question about any Brown Act issue, seek legal advice. If even one member of the Board questions whether an action can be taken at the meeting, or has been properly noticed, it may be wisest to refer the issue to another meeting and seek legal counsel.

GOVERNMENT CODE SECTION 54950-54963:
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=gov&group=54001-55000&file=54950-54963

SECTION 4

ROBERT'S RULES OF ORDER

Robert's Rules of Order, Newly Revised (RONR) describes one way to run effective meetings. No organization is required to use RONR, but every organization needs to define how the organization will run meetings.

WHAT HAPPENS AT THE MEETING?

The **chairperson** runs the meetings. The chair may be elected or appointed and has the responsibility to run the meeting.
The **secretary** is responsible for making a written record of what is done, usually called the **minutes.** The minutes must capture each action that a board takes but does not need to capture all the discussion of the meeting.
A **quorum**, or a minimum number of members who must be present, is required in order for a meeting to conduct business. Usually a quorum is more than half of the membership.
A meeting has a standard order of business or an **agenda.** The agenda will include a "call to order", reading and approval of minutes, reports, and other business.
A **motion** is a formal proposal from a member of the group to take action. There are many types of motions, but the most common is a motion to take a certain action. The motion is introduced by a member when s/he says "*I move that…."*.
In order to take action on a motion, a member must **second** the motion. The motion is **debated** or discussed by the group prior to a vote.
When the group is ready to vote, the chair reads the motion on the floor, indicates that it has been seconded and discussed, and asks for the "yes" votes, the "no" votes and any abstentions.
An **abstention** is a refusal to vote.

For further information consult Robert's Rules of Order New Revised, 11th revision:
http://www.robertsrules.com

SECTION 5

ORGANIZATIONS CONNECTED TO THE MENTAL HEALTH SYSTEM

There are many organizations involved in assuring that adequate mental health services are provided in CA.

- American Society of Addiction Medicine (ASAM)
- California Association of Behavioral Health Boards and Commissions (CABHB/C)
- California Mental health Services Authority (CalMHSA)
- County Behavioral Health Directors Association of California (CBHDA)
- California Coalition for Mental Health (CCMH)
- California Council of Community Mental Health Agencies (CCCMHA)
- California Institute for Behavior Health Solutions (CIBHS)
- California Mental health Planning Council (CMHPC)
- California Youth Empowerment Network (CAYEN)
- California Department of Health Care Services (DHCS)
- Each Mind Matters
- Know the Signs
- Mental Health American of California (MHA)
- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- National Alliance on Mental Illness (NAMI)
- United Advocates for Children and Families (UACF)

Details on many of these organizations are provided in Appendix F.

APPENDIX A:

- California Welfare and Institutions Code Sections 5604 et seq.
- California Welfare and institutions Code Sections 5650-5667
- Welfare and Institutions Code Section 5750-5772
- AB 1234: Ethics Training & Government Code 87103

California Welfare & Institutions Code Sections 5604-5604.5

5604. (a(1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of less than 80,000 may have a minimum of five members. One member of the board shall be a member of the local governing body. Any county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. Nothing in this section shall be construed to limit the ability of the governing body to increase the number of members above 15. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.

(2) Fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(3) (A) In counties under 80,000 population, at least one member shall be a consumer, and at least one member shall be a parent, spouse, sibling, or adult child of a consumer, who is receiving, or has received, mental health services.

(B) Notwithstanding subparagraph (A), a board in a county with a population under 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

(b) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

(c) If two or more local agencies jointly establish a community mental health service under Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.

(d) (1) Except as provided in paragraph (2), no member of the board or his or her spouse shall be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(2) A consumer of mental health services who has obtained employment with an employer described in paragraph (1) and who holds a position in which he or she does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the board. The member shall abstain from voting on any financial or contractual issue concerning his or her employer that may come before the board.

(e) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(f) If it is not possible to secure membership as specified in this section from among persons who reside in the county, the governing body may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the county mental health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

(g) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

5604.1. Local mental health advisory boards shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.

5604.2. (a) The local mental health board shall do all of the following:
(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.
(2) Review any county agreements entered into pursuant to Section 5650.
(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.
(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.
(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.
(7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.
(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.
(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community

5604.3. The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses may include travel, lodging, child care, and meals for the members of an advisory board while on official business as approved by the director of the local mental health program.

5604.5. The local mental health board shall develop bylaws to be approved by the governing body which shall:
(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.
(b) Ensure that the composition of the mental health board represents the demographics of the county as a whole, to the extent feasible.
(c) Establish that a quorum be one person more than one-half of the appointed members.
(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.
(e) Establish that there may be an executive committee of the mental health board.

Welfare & Institutions Code Section 5650-5667

5650. a) The board of supervisors of each county, or boards of supervisors of counties acting jointly, shall adopt, and submit to the Director of Health Care Services in the form and according to the procedures specified by the director, a proposed annual county mental health services performance contract for mental health services in the county or counties.

(b) The State Department of Health Care Services shall develop and implement the requirements, format, procedure, and submission dates for the preparation and submission of the proposed performance contract.

5650.5. Any other provision of law referring to the county Short-Doyle plan shall be construed as referring to the county mental health services performance contract described in this chapter.

5651. The proposed annual county mental health services performance contract shall include all of the following:

(a) The following assurances:

(1) That the county is in compliance with the expenditure requirements of Section 17608.05.

(2) That the county shall provide services to persons receiving involuntary treatment as required by Part 1 (commencing with Section 5000) and Part 1.5 (commencing with Section 5585).

(3) That the county shall comply with all requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals, including, but not limited to, the provisions set forth in Chapter 3 (commencing with Section 5700), and that the county shall submit cost reports and other data to the department in the form and manner determined by the State Department of Health Care Services.

(4) That the local mental health advisory board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process pursuant to Section 5604.2.

(5) That the county shall comply with all provisions and requirements in law pertaining to patient rights.

(6) That the county shall comply with all requirements in federal law and regulation pertaining to federally funded mental health programs.

(7) That the county shall provide all data and information set forth in Sections 5610 and 5664.

(8) That the county, if it elects to provide the services described in Chapter 2.5 (commencing with Section 5670), shall comply with guidelines established for program initiatives outlined in that chapter.

(9) Assurances that the county shall comply with all applicable laws and regulations for all services delivered, including all laws, regulations, and guidelines of the Mental Health Services Act.

(b) Any contractual requirements needed for any program initiatives utilized by the county contained within this part. In addition, any county may choose to include contract provisions for other state directed mental health managed programs within this performance contract.

(c) The State Department of Health Care Services' ability to monitor the county's three-year program and expenditure plan and annual update pursuant to Section 5847.

(d) Other information determined to be necessary by the director, to the extent this requirement does not substantially increase county costs.

5651.2. For the 1991-92 fiscal year, each county shall, no later than October 1, 1991, submit to the department a simplified performance contract. The performance contract shall contain information that the department determines

necessary for the provision and funding of mental health services provided for in law. The performance contract shall include, but not be limited to, assurances necessary to ensure compliance with federal law. In addition, the performance contract may include provisions governing reimbursement to the state for costs associated with state hospitals and institutions for mental disease.

5652.5. (a) Each county shall utilize available private and private nonprofit mental health resources and facilities in the county prior to developing new county-operated resources or facilities when these private and private nonprofit mental health resources or facilities are of at least equal quality and cost as county-operated resources and facilities and shall utilize available county resources and facilities of at least equal quality and cost prior to new private and private nonprofit resources and facilities. All the available local public or private and private nonprofit facilities shall be utilized before state hospitals are used.

(b) Nothing in this section shall prevent a county from restructuring its systems of care in the manner it believes will provide the best overall care.

5652.7. A county shall have only 60 days from the date of submission of an application to review and certify or deny an application to establish a new mental health care provider. If an application requires review by the State Department of Health Care Services, the department shall also have only 60 days from the date of submission of the application to review and certify or deny an application to establish a new mental health care provider.

5653. (a) Optimum use shall be made of appropriate local public and private organizations, community professional personnel, and state agencies. Optimum use shall also be made of federal, state, county, and private funds that may be available for mental health planning.

(b) In order that maximum utilization be made of federal and other funds made available to the Department of Rehabilitation, the Department of Rehabilitation may serve as a contractual provider under the provisions of a county plan of vocational rehabilitation services for persons with mental health disorders.

5653.1. In conducting evaluation, planning, and research activities, counties may contract with public or private agencies.

5654. In order to serve the increasing needs of children and adolescents with mental and emotional problems, county mental health programs may use funds for the purposes of consultation and training.

5655. All departments of state government and all local public agencies shall cooperate with county officials to assist them in mental health planning. The State Department of Health Care Services shall, upon request and with available staff, provide consultation services to the local mental health directors, local governing bodies, and local mental health advisory boards.

If the Director of Health Care Services considers any county to be failing, in a substantial manner, to comply with any provision of this code or any regulation, the director shall order the county to appear at a hearing, before the director or the director's designee, to show cause why the department should not take action as set forth in this section. The county shall be given at least 20 days' notice of the hearing. The director shall consider the case on the record established at the hearing and make final findings and decision.

If the director determines that there is or has been a failure, in a substantial manner, on the part of the county to comply with any provision of this code or any regulations, and that administrative sanctions are necessary, the department may invoke any, or any combination of, the following sanctions:

(a) Withhold part or all of state mental health funds from the county.

(b) Require the county to enter into negotiations for the purpose of ensuring county compliance with those laws and regulations.

(c) Bring an action in mandamus or any other action in court as may be appropriate to compel compliance. Any action filed in accordance with this section shall be entitled to a preference in setting a date for a hearing.

5657. (a) The private organization or private nonprofit organization awarded a contract with the county agency to supply mental health services under this part shall provide an invoice to the county for the amount of the payment due within 60 days of the date the services are supplied, as long as that date is at least 60 days from the date the county has received distribution of mental health funds from the state.

(b) Any county that, without reasonable cause, fails to make any payment within 60 days of the required payment date to a private organization or private nonprofit organization awarded a contract with the county agency to supply mental health services under this part, for an undisputed claim which was properly executed by the claimant and submitted to the county, shall pay a penalty of 0.10 percent of the amount due, per day, from the 61st day after the required payment date.

(c) For the purposes of this section, "required payment date" means any of the following:

(1) The date on which payment is due under the terms of the contract.

(2) If a specific date is not established by contract, the date upon which an invoice is received, if the invoice specifies payment is due upon receipt.

(3) If a specific date is not established by contract or invoice, 60 days after receipt of a proper invoice for the amount of the payment due.

(d) The penalty assessed under this section shall not be paid from the Bronzan-McCorquodale program funds or county matching funds. The penalty provisions of this section shall not apply to the late payment of any federal funds or Medi-Cal funds.

5664. In consultation with the California Mental Health Directors Association, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Planning Council, and the California Health and Human Services Agency, county mental health systems shall provide reports and data to meet the information needs of the state, as necessary.

5665. After the development of performance outcome measures pursuant to Section 5610, whenever a county makes a substantial change in its allocation of mental health funds among services, facilities, programs, and providers, it shall, at a regularly scheduled public hearing of the board of supervisors, document that it based its decision on the most cost-effective use of available resources to maximize overall client outcomes, and provide this documentation to the department.

5666. (a) The Director of Health Care Services, or his or her designee, shall review each proposed county mental health services performance contract to determine that it complies with the requirements of this division.

(b) The director or his or her designee shall require modifications in the proposed county mental health services performance contract which he or she deems necessary to bring the proposed contract into conformance with the requirements of this division.

(c) Upon approval by both parties, the provisions of the performance contract required by Section 5651 shall be deemed to be a contractual arrangement between the state and county.

5667. (a) A community mental health center shall be considered to be a licensed facility for all purposes, including all provisions of the Health and Safety Code and the Insurance Code.

(b) For purposes of this section, "community mental health center" means any entity that is one of the following:

(1) A city or county mental health program.

(2) A facility funded under the federal Community Mental Health Centers Act, contained in Subchapter 3 (commencing with Section 2681) of Chapter 33 of Title 42 of the United States Code.

(3) A nonprofit agency that has a contract with a county mental health program to provide both of the following:

(A) A comprehensive program of mental health services in an outpatient setting designed to improve the function of persons with diagnosed mental health problems pursuant to procedures governing all aspects of the program formulated with the aid of multidisciplinary staff, including physicians and surgeons, all of whom serve on quality assurance and utilization review committees.

(B) Diagnostic and therapeutic services for individuals with diagnosed mental health problems, together with related counseling.

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5750. The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the California Mental Health Directors Association and the California Mental Health Planning Council.

5751. (a) Regulations pertaining to the qualifications of directors of local mental health services shall be administered in accordance with Section 5607. These standards may include the maintenance of records of service which shall be reported to the State Department of Health Care Services in a manner and at times as it may specify.

(b) Regulations pertaining to the position of director of local mental health services, where the local director is other than the local health officer or medical administrator of the county hospitals, shall require that the director be a psychiatrist, psychologist, clinical social worker, marriage and family therapist, professional clinical counselor, registered nurse, or hospital administrator, who meets standards of education and experience established by the Director of Health Care Services. Where the director is not a psychiatrist, the program shall have a psychiatrist licensed to practice medicine in this state and who shall provide to patients medical care and services as authorized by Section 2051 of the Business and Professions Code.

(c) The regulations shall be adopted in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

5751.1. Regulations pertaining to the position of director of local mental health services, where the local director is other than the local health officer or medical administrator of the county hospitals, shall require that the director meet the standards of education and experience established by the Director of Health Care Services and that the appointment be open on the basis of competence to all eligible disciplines pursuant to Section 5751. Regulations pertaining to the qualifications of directors of local mental health services shall be administered in accordance with Section 5607.

Where the director of local mental health services is not a psychiatrist, the program shall have a psychiatrist licensed to practice medicine in this state and who shall provide to patients medical care and services as authorized by Section 2137 of the Business and Professions Code.

5751.2. a) Except as provided in this section, persons employed or under contract to provide mental health services pursuant to this part shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs pursuant to this part to provide services for which a license is required, unless the person possesses a valid license.

(b) Persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same program or facility, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirements of subdivision (a).

(c) While registered with the licensing board of jurisdiction for the purpose of acquiring the experience required for licensure, persons employed or under contract to provide mental health services pursuant to this part as clinical social workers, marriage and family therapists, or professional

clinical counselors shall be exempt from subdivision (a). Registration shall be subject to regulations adopted by the appropriate licensing board.

(d) The requirements of subdivision (a) shall be waived by the State Department of Health Care Services for persons employed or under contract to provide mental health services pursuant to this part as psychologists who are gaining the experience required for licensure. A waiver granted under this subdivision may not exceed five years from the date of employment by, or contract with, a local mental health program for persons in the profession of psychology.

(e) The requirements of subdivision (a) shall be waived by the State Department of Health Care Services for persons who have been recruited for employment from outside this state as psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors and whose experience is sufficient to gain admission to a licensing examination. A waiver granted under this subdivision may not exceed three years from the date of employment by, or contract with, a local mental health program for persons in these four professions who are recruited from outside this state.

5751.7. (a) For the purposes of this part and the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000)), the State Department of Health Care Services and the State Department of State Hospitals shall ensure that, whenever feasible, minors shall not be admitted into psychiatric treatment with adults if the health facility has no specific separate housing arrangements, treatment staff, and treatment programs designed to serve children or adolescents. The Director of Health Care Services shall provide waivers to counties, upon their request, if this policy creates undue hardship in any county due to inadequate or unavailable alternative resources. In granting the waivers, the Director of Health Care
Services shall require the county to establish specific treatment protocols and administrative procedures for identifying and providing appropriate treatment to minors admitted with adults.

(b) However, notwithstanding any other provision of law, no minor may be admitted for psychiatric treatment into the same treatment ward as any adult receiving treatment who is in the custody of any jailor for a violent crime, is a known registered sex offender, or has a known history of, or exhibits inappropriate, sexual, or other violent behavior which would present a threat to the physical safety of minors.

5755.1. The state mental health plan shall be submitted to the California Council on Mental Health and the Advisory Health Council or its successor for review and recommendations as to conformance with California's comprehensive statewide health plan. The state mental health plan shall be submitted for review and recommendations prior to amendments or changes thereto.

5767. The department, in consultation with a statewide organization representing county mental health services, shall strengthen and ensure statewide application of managed care principles, building on existing county systems, to manage the Early Periodic Screening Diagnosis and Treatment Program benefit while ensuring access to eligible Medi-Cal recipients.

5768. (a) Notwithstanding any other provision of law, except as to requirements relating to fire and life safety of persons with mental illness, the State Department of Health Care Services, in its discretion, may permit new programs to be developed and implemented without complying with licensure requirements established pursuant to existing state law.

(b) Any program developed and implemented pursuant to subdivision (a) shall be reviewed at least once each six months, as determined by the State Department of Health Care Services.

(c) The State Department of Health Care Services may establish appropriate licensing requirements for these new programs upon a determination that the programs should be continued.

(d) Within six years, any program shall require a licensure category if it is to be continued. However, in the event that any agency other than the State Department of Health Care Services is responsible for developing a licensure category and fails to do so within the six years, the program may continue to be developed and implemented pursuant to subdivisions (a) and (b) until such time that the licensure category is established.

(e) (1) A nongovernmental entity proposing a program shall submit a program application and plan to the local mental health director that describes at least the following components: clinical treatment programs, activity programs, administrative policies and procedures, admissions, discharge planning, health records content, health records service, interdisciplinary treatment teams, client empowerment, patient rights, pharmaceutical services, program space requirements, psychiatric and psychological services, rehabilitation services, restraint and seclusion, space, supplies, equipment, and staffing standards. If the local mental health director determines that the application and plan are consistent with local needs and satisfactorily address the above components, he or she may approve the application and plan and forward them to the department.

(2) Upon the State Department of Health Care Services' approval, the local mental health director shall implement the program and shall be responsible for regular program oversight and monitoring. The department shall be notified in writing of the outcome of each review of the program by the local mental health director, or his or her designee, for compliance with program requirements. The department shall retain ultimate responsibility for approving the method for review of each program, and the authority for determining the appropriateness of the local program's oversight and monitoring activities.

(f) Governmental entities proposing a program shall submit a program application and plan to the State Department of Health Care Services that describes at least the components described in subdivision (e). Upon approval, the department shall be responsible for program oversight and monitoring.

(g) Implementation of a program shall be contingent upon the State Department of Health Care Services' approval, and the department may reject applications or require modifications as it deems necessary. The department shall respond to each proposal within 90 days of receipt.

(h) The State Department of Health Care Services shall submit an evaluation to the Legislature of all pilot projects authorized pursuant to this section within five years of the commencement of operation of the pilot project, determining the effectiveness of that program or facility, or both, based on, but not limited to, changes in clinical indicators with respect to client functions.

5768.5. (a) When a mental health patient is being discharged from any facility authorized under Section 5675 or 5768, the patient and the patient's conservator, guardian, or other legally authorized representative shall be given a written aftercare plan prior to the patient's discharge from the facility. The written aftercare plan shall include, to the extent known, the following components:

(1) The nature of the illness and follow-up required.

(2) Medications, including side effects and dosage schedules. If the patient was given an informed consent form with his or her medications, the form shall satisfy the requirement for information on side effects of the medications.

(3) Expected course of recovery.

(4) Recommendations regarding treatment that are relevant to the patient's care.

(5) Referrals to providers of medical and mental health services.

(6) Other relevant information.

(b) The patient shall be advised by facility personnel that he or she may designate another person to receive a copy of the aftercare plan. A copy of the aftercare plan shall be given to any person designated by the patient.

(c) For purposes of this section, "mental health patient" means a person who is admitted to the facility primarily for the diagnosis or treatment of a mental disorder.

5769. Whenever the director determines that a county's personnel regulations and procedures are impediments to the timely implementation of programs developed and implemented pursuant to Section 5768, the director shall communicate such determination to the governing body of such county.

5770. Notwithstanding any other provision of law, the State Department of Health Care Services may directly, or by contract, with any public or private agency, provide any of the services under this division when the state determines that the services are necessary to protect the public health, safety, or welfare.

5770.5. The State Department of Health Care Services shall encourage county mental health programs to develop and support local programs designed to provide technical assistance to self-help groups for the purposes of maintaining existing groups, as well as to stimulate development of new self-help groups from locally defined needs.

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

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

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

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.

5771.3. The California Mental Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on the performance of programs annually to the Legislature, the State Department of Health Care Services, and the local boards, and to post those findings and recommendations annually on its Internet Web site.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.

(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.

(i) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.

(j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.

(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

(l) To suggest rules, regulations, and standards for the administration of this division.

(m) When requested, to mediate disputes between counties and the state arising under this part.

(n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.

(o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

(p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

GOVERNMENT CODE Section 87103

87103. A public official has a financial interest in a decision within the meaning of Section 87100 if it is reasonably foreseeable that the decision will have a material financial effect, distinguishable from its effect on the public generally, on the official, a member of his or her immediate family, or on any of the
following:

(a) Any business entity in which the public official has a direct or indirect investment worth two thousand dollars ($2,000) or more.

(b) Any real property in which the public official has a direct or indirect interest worth two thousand dollars ($2,000) or more.

(c) Any source of income, except gifts or loans by a commercial lending institution made in the regular course of business on terms available to the public without regard to official status, aggregating five hundred dollars ($500) or more in value provided or promised to, received by, the public official within 12 months prior to the time when the decision is made.

(d) Any business entity in which the public official is a director, officer, partner, trustee, employee, or holds any position of management.

(e) Any donor of, or any intermediary or agent for a donor of, a gift or gifts aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the public official within 12 months prior to the time when the decision is made. The amount of the value of gifts specified by this subdivision shall be adjusted biennially by the commission to equal the same amount determined by the commission pursuant to subdivision (f) of Section 89503.

For purposes of this section, indirect investment or interest means any investment or interest owned by the spouse or dependent child of a public official, by an agent on behalf of a public official, or by a business entity or trust in which the official, the official's agents, spouse, and dependent children own directly, indirectly, or beneficially a 10-percent interest or greater.

APPENDIX B

Mental Health Services Act

MENTAL HEALTH SERVICES ACT As Revised September 2013

SECTION 1. Title This Act shall be known and may be cited as the “Mental Health Services Act.”

SECTION 2. Findings and Declarations The people of the State of California hereby find and declare all of the following:
(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.
(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.
(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.
(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.
(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President’s Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.
(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.
(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multimillion 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 State Department of Health Care Services, in coordination with counties, 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) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.
(f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, 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 ensure 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 his or her 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 (commencing with Section 5890), 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 Medi-Cal, 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 (commencing with Section 18250) of Part 6 of Division 9.
(c) The State Department of Health Care Services 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:
18257. (a) The State 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.

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 state 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 subdivisions (b) and (c) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in Part 3 (commencing with Section 5800) of this division.
(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 program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.
(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 (commencing with Section 5890) of this division, 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. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).
(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 (commencing with Section 5820) is hereby added to Division 5 of the Welfare and Institutions Code, to read:
PART 3.1 HUMAN RESOURCES, 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 Office of Statewide Health Planning and Development 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 Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) 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 Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information 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, with the next five year plan due as of April 1, 2014.
(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.
5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development. (b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.
5822. The Office of Statewide Health Planning and Development 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 between 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 Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.
(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 meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.
(j) 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) All projects included in the innovative program portion of the county plan shall meet the following requirements:
(1) Address one of the following purposes as its primary purpose:
(A) Increase access to underserved groups.
(B) Increase the quality of services, including measurable outcomes.
(C) Promote interagency and community collaboration.
(D) Increase access to services.
(2) Support innovative approaches by doing one of the following:
(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.
(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:
(1) Administrative, governance, and organizational practices, processes, or procedures.
(2) Advocacy.
(3) Education and training for service providers, including nontraditional mental health practitioners.
(4) Outreach, capacity building, and community development.
(5) System development.

(6) Public education efforts.
(7) Research.
(8) Services and interventions, including prevention, early intervention, and treatment.
(d) If an innovative project has proven to be successful and a county chooses to continue it, the project work plan shall transition to another category of funding as appropriate.
(e) County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services 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 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), 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. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.
(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) Enter into contracts.
(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decision making process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.
(8) Develop strategies to overcome stigma and discrimination and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.
(9) 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.
(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.
(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the California Mental Health Directors Association.
(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.
5846. (a) The commission shall adopt regulations for programs and expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention.
(b) Any regulations adopted by the department pursuant to Section 5898 shall be consistent with the commission's regulations.
(c) The commission 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.
(d) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.
5847. Integrated Plans for Prevention, Innovation, and System of Care Services.
(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.
(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:
(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).
(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.
(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).
(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).
(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). 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 (commencing with Section 5820).

(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 Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, 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.
(8) Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and non-supplantation requirements.
(9) Certification by the county mental health director and by the county auditor controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.
(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.
(d) Each year, the State Department of Health Care Services shall inform the California Mental Health Directors Association and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.
(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and Part 4 (commencing with Section 5850) for services for children, 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 Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), 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.
(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) 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 three-year program and expenditure 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, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. 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 the draft plans.
(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30–day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure 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 plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840, and Part 4 (commencing with Section 5850) of this division funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services

Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.
(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

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) of Division 2, 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 re-computation 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 1 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 15 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 1 of the year that is two 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 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 Estimated Revenue from Additional Tax Fiscal Year 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 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 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 state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, 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 3.2 (commencing with Section 5830), Innovative Programs.
(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) 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 these 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 State Department of Health Care Services.
(d) The State Department of Health Care Services 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 Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this 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 Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.
5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, 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 or from the Local Revenue Fund 2011 in the State Treasury, 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.
(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.
(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).
(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).
5892. (a) In order to promote efficient implementation of this act the county shall use funds distributed from the Mental Health Services Fund as follows:
(1) In 2005-06, 2006-07, and in 2007-08 10 percent 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 percent 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) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.
(4) The a expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.
(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 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.
6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.
(b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division 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 percent 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 these costs shall not exceed 5 percent 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 Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.
(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent 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 Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.
(e) In 2004-05 funds shall be allocated as follows: (1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division. (2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a). (3) Five percent for local planning in the manner specified in subdivision (c). (4) Five percent 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 the 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 10 years before reverting to the fund.
(i) If there are still additional revenues available in the fund after the Mental Health Services 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 these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.
(j) For the 2011-12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011-12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:
(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the California Mental Health Directors Association to meet the fiscal year 2011-12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.
(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the California Mental Health Directors Association.
(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011-12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.
(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for fiscal year 2011-12. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the California Mental Health Directors Association. These funds shall not be subject to reconciliation or cost settlement.
(5) The Controller shall distribute to counties the remaining 2011-12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.
(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in fiscal year 2011-12 that exceed this obligation shall be distributed to counties for remaining fiscal year 2011-12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.
(k) Subdivision (j) shall not be subject to repayment.
(l) Subdivision (j) shall become inoperative on July 1, 2012.
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 Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) of this division, 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 (commencing with Section 5800), or Part 4 (commencing with Section 5850) 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 State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) 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 Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5. (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 timeline to achieve improvements.
(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with 5800), Part 3.1 (commencing with 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, 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 State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.
5898. The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.
5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.
(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:
(1) Identify the expenditures of the Mental Health Services Act (MHSA) funds that were distributed to each county.
(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.
(3) Identify unexpended funds, and interest earned on MHSA funds.
(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of the following:
(1) Children's systems of care.
2) Prevention and early intervention strategies.
(3) Innovative projects.
4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

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 12 of this act.

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. SECTION 1 (of AB 100)
(a) The Legislature hereby finds and declares that the statutory changes in this act are consistent with, and further the intent of, the Mental Health Services Act. These specified changes are necessary to adequately fund essential mental health services that would otherwise be significantly and substantially reduced or eliminated absent this temporary funding support.
(b) Further, it is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act. In eliminating state approval of county mental health programs, the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services.

APPENDIX C

The Ralph M. Brown Act

The legislation can be found in the California Government Code Sections 54950-54963: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=gov&group=54001-55000&file=54950-54963

APPENDIX D

Roberts Rules of Order, Newly Revised:

- How To Make A Motion
- RONR Quiz
- RONR Answers

HOW TO MAKE A MOTION:

Discussion in a body occurs following a motion. Having a motion on the floor helps the chair to direct the conversation appropriately. The group should vote on **exact language** not a vague idea. In the end the motion needs to be written in the minutes accurately.

The proper way to make a motion:

- The individual wishing to make a motion is called upon by the chair of the body
- The individual states the motion clearly for the body provides a written copy of the motion to the chair without further discussion
    - Anyone in the body may call out "second" to support the motion. The person making the second does not change the motion. If there is no second, the motion dies
- If there is a second, the chair repeats the motion for the body in order to direct discussion: "The motion on the floor is…"
    - The chair calls for discussion/debate on the motion from the maker of the motion: "Do you wish to speak to your motion?"
    - Following input from the maker of the motion, the chair asks for debate on the motion.
- *If an individual wishes to amend the motion:*
    - The individual states "I wish to amend the motion and insert/strike the words… (or the paragraph). The motion must be seconded.
    - The chair states: The motion on the floor is…" and asks for input from the maker of the motion.
    - Following input from the maker of the motion, the chair asks for debate on the motion until the body is ready for the question.
- *If an individual wishes to close debate:*
    - The individual states "I move the previous question.". The motion must be seconded. This closes debate.
    - The motion to close debate requires a two-thirds vote.
    - The chair presents the motion: "It is moved and seconded to order the previous question. Those in favor say "yes", those opposed say "no".
    - The chair presents the results of the motion: There are two-thirds in the affirmative and the previous question is ordered. The question is now on the adoption of the motion…."
    - Once the body has voted on an amendment, the specific matter is considered settled.
- When discussion ends, the chair may ask: "Are you ready for the question?" If so, the chair repeats the motion on the floor: "The question is on the adoption of the motion that…" and repeats the exact motion.
    - The chair asks for "yes" votes, "no" votes and "abstentions".
    - The chair announces the results of the vote: "The ayes have it and the motion is adopted."

ROBERTS RULES OF ORDER
QUIZ

_____ The President can vote only to break a tie.

_____ Once a quorum has been established it continues to exist no matter how many members leave during the course of the meeting.

_____ Abstention votes count.

_____ A member with a conflict of interest with respect to a motion cannot vote on the motion.

_____ Debate on a motion must stop as soon as any member calls the question.

_____ Anyone can add an item to an agenda.

_____ Minutes of a meeting need to contain all the information from the meeting.

_____ A board meeting cannot be held by telephone.

QUIZ: ROBERTS RULES OF ORDER (NEWLY REVISED)

_____ **The President can vote only to break a tie.**
NO: *the presiding officer has the same rights as any other member of the body. The presiding officer of an assembly of more than about a dozen members should make every effort to maintain an appearance of impartiality so that members on both sides of any issue can feel confident they will receive fair treatment. To this end the chair does not participate in debate on any issue unless (s)he gives up the chair. The chair votes only when either*

- *The vote is by ballot, in which case the chair votes along with and at the same time as all other members, or*
- *The chair's vote will change the result of the vote.*

_____ **Once a quorum has been established it continues to exist no matter how many members leave during the course of the meeting.**
NO: *Even when a meeting begins with a quorum present, it loses its right to conduct substantive business whenever enough members leave to bring attendance below the level of a quorum. It can resume substantive business only when enough members return, or other members arrive, to give it a quorum again.*

_____ **Abstention votes count.**
NO. *Abstentions are instances in which members who are present refuse to vote. In the usual situation where either a majority vote or a two-thirds vote is required, abstentions are not counted and have no effect on the result. However, if the vote required is a majority or two-thirds* ***of the members present****, an abstention has the same effect as a "no" vote.*

_____ **A member with a conflict of interest with respect to a motion cannot vote on the motion.**
DEPENDS: *Brown Act is YES.*
RRONR NO: *You should not vote on a question in which you have a direct personal or monetary interest not common to other members. However, you cannot be compelled to abstain because of such a conflict of interest.*

_____ **Debate on a motion must stop as soon as any member "calls the question".**
SORT OF: *The proper wording to close debate on the immediately pending motion is to say "I move the previous question". The body then needs to vote on that motion with a 2/3 vote for adoption. If the motion passes, the body will immediately consider the previous motion with no further debate. Cutting off debate infringes on the right of members to speak, thus debate should never be limited without following the proper procedure.*

_____ **Anyone can add an item to an agenda.**
RRONR YES: *For a proposed agenda to become the official agenda for a meeting, it must be adopted by the assembly at the outset of the meeting. At the time that an agenda is presented for adoption, it is in order for any member to move to amend the proposed agenda by adding any item that the member desires to add, or by proposing any other change.*
BROWN ACT NO: *The agenda provided at least 72 hours in advance of the meeting is the official agenda and cannot be modified except in emergency situations.*

_____ **Minutes of a meeting need to contain all the information from the meeting.**
NO: *Not only is it not necessary to summarize matters discussed at a meeting in the minutes of that meeting, it is improper to do so. Minutes are a record of what was done at a meeting, not what was said.*

_____ **A board meeting cannot be held by telephone.**
NO: *You may hold board meetings by conference telephone call only if your bylaws specifically authorize you to do so. If they do, such meetings must be conducted in such a way that all members participating can hear each other at the same times, and special rules should be adopted to specify precisely how recognition is to be sought and the floor obtained during such meetings.*

APPENDIX E

Facility Monitoring Checklist

FACILITY MONITORING CHECKLIST:

Facility Name:
Address:
Date of Review:
License is dated:
and has the following exceptions:
Name of Reviewers:

The facility is clean and safe based on the following:		Met	Needs Work	Unmet
○ Temperature is comfortable and safe	(T22 80088)	☐	☐	☐
○ Facility and grounds are free of hazards	(T22 80087)	☐	☐	☐
○ Fire alarms/extinguishers are operable	(T22 80020)	☐	☐	☐
○ Client bedrooms are clean and afford privacy	(T22 80087)	☐	☐	☐
○ Client bathrooms are clean and afford privacy	(T22 80087)	☐	☐	☐
○ Toxic items are safely stored	(T22 80087)	☐	☐	☐
Food service provides meals that appear to be of quantity and quality necessary to meet the needs of the clients:				
○ An adequate food supply is available	(T22 80076)	☐	☐	☐
○ Food is adequately stored	(T22 90076)	☐	☐	☐
○ Sanitation practices are adequate	(T22 80076)	☐	☐	☐
○ Residents with special diets receive appropriate food and have prescriptions on file	(T22 80076)	☐	☐	☐
Centrally stored medications are locked	(T22 80075)	☐	☐	☐
Facility staff has training in First Aid	(T22 80075)	☐	☐	☐
First aid supplies and manual are available	(T22 80075)	☐	☐	☐
Fire drills are practiced monthly and documented	(T22 80023)	☐	☐	☐
Vehicles transporting clients are in good repair	(T22 80074)	☐	☐	☐
Facility maintains records of accounts of cash resources, personal property and valuables entrusted to the facility including:	(T22 80026)	☐	☐	☐
○ A current ledger				
○ Supporting receipts for purchases				
○ Receipts for client cash expenditures				
Cash resources are locked and secure on the premises	(T22 80026)	☐	☐	☐

Comments:

APPENDIX F

ORGANIZATIONS CONNECTED TO THE MENTAL HEALTH SYSTEM

- American Society of Addiction Medicine (ASAM)
- California Association of Behavioral Health Boards and Commissions (CABHB/C)
- California Mental health Services Authority (CalMHSA)
- County Behavioral Health Directors Association of California (CBHDA)
- California Coalition for Mental Health (CCMH)
- California Council of Community Mental Health Agencies (CCCMHA)
- California Institute for Behavior Health Solutions (CIBHS)
- California Mental health Planning Council (CMHPC)
- California Youth Empowerment Network (CAYEN)
- California Department of Health Care Services (DHCS)
- Each Mind Matters
- Know the Signs
- Mental Health American of California (MHA)
- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- National Alliance on Mental Illness (NAMI)
- United Advocates for Children and Families (UACF)