CONTRA COSTA HEALTH SERVICES

CPAW MEETING

Date of Meeting: Thursday, December 1st 2011
3:00 PM to 5:40 PM
2425 Bisso Lane, Suite 100, Concord, CA 94520

Staff Lead: Mary Roy
Staff Support: Jeromy Collado

Facilitator: Leigh Marz

AGENDA

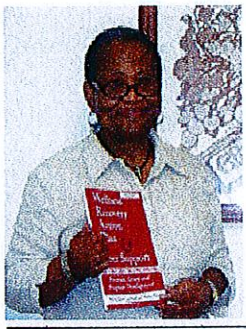
TIME	TOPIC	PRESENTER	DESIRED OUTCOMES	MINUTES
3:00 PM	1. Opening, Agenda Review Announcements: ○ Public Comment ○ Planning Committee Election	*Leigh*	*On-Time Start*	10'
3:10 PM	2. Public Comment			5'
3:15 PM	3. Housing Report	*Sandy Rose*	*Informational Update*	15'
3:30 PM	4. Acting Mental Health Director's Report	*Suzanne Tavano*	*Informational Update/ CPAW Structure and Membership*	20'
3:50 PM	5. Small Group Discussion- ○ How can we better achieve the MHSA values for a client-driven, family-driven process? ○ What steps will take us closer to that in 2012?	*Leigh*	*Discussion to build understanding*	35'
4:25 PM	6. Mini-break			10'
4:35 PM	7. TAY FSP	*Holly Page*	*Informational Update*	30'
5:05 PM	8. PEI Program 4: Suicide Prevention	*Mary Roy Holly Page*	*Informational Update*	30'
5:35 PM	1. Public comment (again)			5'
5:40 PM	2. Close	*Leigh*		

CPAW Ground Rules

1. Agendas and minutes of the previous meeting will be emailed before each meeting,
2. Meetings will start and stop on time.
3. One speaker at a time; allow the facilitator to "direct traffic."
4. Speaker's remarks should be brief to allow for others to speak.

5. Listen to and value other points of view, even if they differ from yours.
6. To the greatest extent possible, system interests should trump personal interests.
7. Declare potential conflicts of interest before the topic is discussed.
    - *The person(s) having a conflict with a topic being discussed will refrain from participating in any group discussion on the matter and will physically leave the room for the period of time the topic is considered.*
8. Focus on past stakeholder processes to the extent that it helps the CPAW move forward.
9. When the group makes a decision, seek consensus 1st; a simple majority is the second option.
10. Turn off cell phones, unless your job requires you to be readily available.

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT



1. Candidate Name: Brenda J. Crawford

2. CPAW Member Since (mm/dd/yyyy): 02/2009

3. Candidate Statement: (***150 words maximum***. Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

My role as MHCC Executive Director (the oldest and longest running mental health consumer driven peer support recovery program in the country) requires me to honor and carry out the recovery movement's mission, "Nothing About us, Without us." CPAW should exemplify this and expand it to "Nothing about Us, Without All of Us." At CPAW we have the opportunity to forge new partnerships, develop trust, mutual respect and a culture of transparency. To do that we all must be willing to take bold risks and set aside our programmatic "look goods" and protectionist attitudes. The former New York Governor stated, "Movements are not started because of social injustice, but because of Hope." Wellness Recovery Action Planning (WRAP) says recovery keys are Hope, Personal Responsibility, Education, Self Advocacy and Support. We can use these keys to transform CCC mental health services. Despite all the turmoil, changes and confusion I remain hopeful!

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [x] East Region
- [x] West Region

B. Ethnicity:

- [x] African-American
- [ ] Asian/Pacific Islander
- [ ] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [ ] CSS – Children
- [ ] CSS – TAY
- [x] CSS – Adult
- [x] CSS – Older Adult
- [ ] PEI – 0-25
- [ ] PEI 26+
- [x] WE&T
- [ ] Capital Facilities/ IT

D. Community:

- [ ] Education
- [ ] Faith
- [x] Health Provider
- [ ] Veterans
- [ ] Law Enforcement
- [x] LGBTQ
- [ ] Other: Senior

E. Perspective:

- [x] Consumer
- [x] Family Member
- [x] MH Contractor
- [ ] MH County Staff

5. My Primary Stakeholder Representation is:

Consumer / Provider / Family Member

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Brenda J. Crawford

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [x] Aging & Older Adults
- [x] Innovation
- [ ] Housing
- [ ] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [x] Capital Facilities / IT
- [ ] Data

C. Ad Hoc Committees

- [ ] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [ ] No
- [x] Yes. *Please Describe*:

MHCC receives funding for its Wellness & Recovery Centers and for the SPIRIT program.

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [ ] Child & Advocacy Task Force (CATF)
- [x] Human Services Alliance
- [x] Mental Health Coalition
- [ ] MHC
- [x] NAMI
- [ ] Union Affiliation
- [ ] Other: _____

THANK YOU

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Leigh Marz at leighmarz@sbcglobal.net
by Thursday, November 17, 2011, at Noon.

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

1. Candidate Name: John Gragnani

2. CPAW Member Since (mm/dd/yyyy): 02/2009

3. Candidate Statement: (***150 words maximum.*** Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

I wish to continue on the CPAW Planning Committee is to serve CPAW and our fragile community mental health (behavioral health) system. Contributing to a positive systemic transformation is also important to me; though I believe we have a long way to go in that regard. I believe we must improve transparency, predictability, and consistency in our systemic structures and communication. That has been the main priority of mine from the start of my involvement on CPAW and the Planning Committee, and progress has been slow at best (my opinion).

That said I believe that CPAW has worked best by allowing us all the opportunities to get to know each other, whom we represent, to see and experience our diversity, to contribute to our fragile system, to strive for the greater good, and identify our shared hopes as we persevere forward. So much is at stake, such challenging times.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

☐ Central Region ☑ East Region ☐ West Region

B. Ethnicity:

☐ African-American ☐ Asian/Pacific Islander ☑ Caucasian

☐ Hispanic / Latino ☐ Native American ☐ Other: _____

C. Program Area:

☑ CSS – Children ☐ CSS – TAY ☐ CSS – Adult ☐ CSS – Older Adult

☐ PEI – 0-25 ☐ PEI 26+ ☐ WE&T ☐ Capital Facilities/ IT

D. Community:

☐ Education ☐ Faith ☑ Health Provider ☐ Veterans

☐ Law Enforcement ☐ LGBTQ ☐ Other: _____

E. Perspective:

☐ Consumer ☐ Family Member ☐ MH Contractor ☑ MH County Staff

5. My Primary Stakeholder Representation is:

PEU Local 1 Mental Health

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): John Gragnani

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [ ] Aging & Older Adults
- [ ] Innovation
- [ ] Housing
- [x] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [ ] Capital Facilities / IT
- [ ] Data

C. Ad Hoc Committees

- [ ] Nomination
- Multi Gen Family Therapy

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [ ] No
- [x] Yes. *Please Describe*:

Some MHSA funds go to county-run programs / positions

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [x] Child & Advocacy Task Force (CATF)
- [ ] Human Services Alliance
- [ ] Mental Health Coalition
- [x] MHC
- [ ] NAMI
- [x] Union Affiliation
- [ ] Other: _____

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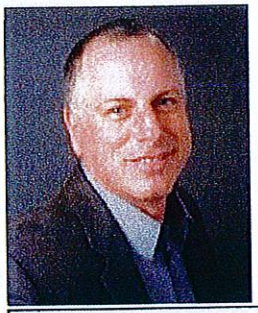
CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT



1. Candidate Name: Steven Grolnic-McClurg

2. CPAW Member Since (mm/dd/yyyy): 02/2009

3. Candidate Statement: (***150 words maximum.*** Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

The mental health system is undergoing extreme stress: there are not enough resources, mental health is integrating into a larger behavioral healthcare division, physical/behavioral healthcare integration is coming -- it seems like nothing is staying the same.

At this time of change, I believe that an open process that involves diverse stakeholders is crucial. Transparency is crucial in building trust, which is deeply needed to make the changes that are needed to our current system of care. In my experience at CPAW and, for the past year, in the planning committee, I have tried my best to support our stakeholder group in giving meaningful and diverse input into the planning process. As a provider and advocate, I bring experience of how funding and policy decisions influence the care consumers receive. I want to continue to participate in creating a system that best meets the needs of mental health consumers.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [x] East Region
- [x] West Region

B. Ethnicity:

- [ ] African-American
- [ ] Asian/Pacific Islander
- [x] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [ ] CSS – Children
- [ ] CSS – TAY
- [x] CSS – Adult
- [ ] CSS – Older Adult
- [ ] PEI – 0-25
- [ ] PEI 26+
- [ ] WE&T
- [ ] Capital Facilities/ IT

D. Community:

- [ ] Education
- [ ] Faith
- [x] Health Provider
- [ ] Veterans
- [ ] Law Enforcement
- [x] LGBTQ
- [ ] Other: _____

E. Perspective:

- [ ] Consumer
- [x] Family Member
- [x] MH Contractor
- [ ] MH County Staff

5. My Primary Stakeholder Representation is:

MH Contractor

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Steven Grolnic-McClurg

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [ ] Aging & Older Adults
- [ ] Innovation
- [ ] Housing
- [ ] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [ ] Capital Facilities / IT
- [x] Data

C. Ad Hoc Committees

- [ ] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [ ] No
- [x] Yes. *Please Describe*:

I direct mental health and wellness services at Rubicon Programs, we receive funding for an adult full service partnership.

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [ ] Child & Advocacy Task Force (CATF)
- [x] Human Services Alliance
- [ ] Mental Health Coalition
- [ ] MHC
- [ ] NAMI
- [ ] Union Affiliation
- [ ] Other: _____

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CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

1. Candidate Name: Molly Hamaker

2. CPAW Member Since (mm/dd/yyyy): 02/2009

3. Candidate Statement: (***150 words maximum.*** Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

I was a member of MHSA's PEI stakeholder committee during its entirety and have been on CPAW since its inception. I helped start and serve on the CPAW Housing Committee and serve on the Social Inclusion Subcommittee. I work as Executive Director of The Contra Costa Clubhouses, Inc., operating Putnam Clubhouse, a collaborative community supporting social and vocational rehabilitation for adults recovering from mental illness. I spent 20 years as a business development consultant. My academic background is in educational psychology; I have a credential as a school psychologist. I've worked in East and West Contra Costa County school districts. My daughter has schizophrenia and lives with me. I'm committed as a parent and a provider to collaborate with other stakeholders to improve mental health services for consumers of all ages and their families. Serving on the Planning Committee allows me to continue helping to transform our mental health system.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [x] East Region
- [x] West Region

B. Ethnicity:

- [ ] African-American
- [ ] Asian/Pacific Islander
- [x] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [ ] CSS – Children
- [ ] CSS – TAY
- [ ] CSS – Adult
- [ ] CSS – Older Adult
- [x] PEI – 0-25
- [x] PEI 26+
- [ ] WE&T
- [ ] Capital Facilities/ IT

D. Community:

- [ ] Education
- [ ] Faith
- [x] Health Provider
- [ ] Veterans
- [ ] Law Enforcement
- [ ] LGBTQ
- [ ] Other: _____

E. Perspective:

- [ ] Consumer
- [x] Family Member
- [x] MH Contractor
- [ ] MH County Staff

5. My Primary Stakeholder Representation is:

Adult consumers and their family members

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Molly Hamaker

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [ ] Aging & Older Adults
- [ ] Innovation
- [x] Housing
- [x] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [ ] Capital Facilities / IT
- [ ] Data

C. Ad Hoc Committees

- [ ] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [ ] No
- [x] Yes. *Please Describe*:

The Contra Costa Clubhouses, Inc. currently receives PEI funding.

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [ ] Child & Advocacy Task Force (CATF)
- [ ] Human Services Alliance
- [ ] Mental Health Coalition
- [ ] MHC
- [x] NAMI
- [ ] Union Affiliation
- [ ] Other: _____

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CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

1. Candidate Name: Kathi McLaughlin

2. CPAW Member Since (mm/dd/yyyy): 02/2009

3. Candidate Statement: (***150 words maximum***. Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

I was asked to serve on CPAW at the beginning of its formation because I had served on the CSS Children's and PEI under 25 community planning groups. I am an active member of several CPAW committees. I was a member of the committee that interviewed a number of facilitators and ultimately selected our current facilitators. They recommended the establishment of a planning committee and I have continued in that role ever since. I am a stakeholder representing education and a program that receives PEI funds. I am a child advocate and try to represent the perspective of children with special needs, including serious emotional disturbance, and their families and caregivers. I am a consumer myself and am the child and grandchild of women with bipolar disorder. I am also a survivor of suicide. My passion is ensuring that all people with mental health needs receive prevention and intervention services.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [ ] East Region
- [ ] West Region

B. Ethnicity:

- [ ] African-American
- [ ] Asian/Pacific Islander
- [x] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [x] CSS – Children
- [x] CSS – TAY
- [ ] CSS – Adult
- [ ] CSS – Older Adult
- [x] PEI – 0-25
- [ ] PEI 26+
- [ ] WE&T
- [x] Capital Facilities/ IT

D. Community:

- [x] Education
- [ ] Faith
- [ ] Health Provider
- [ ] Veterans
- [ ] Law Enforcement
- [ ] LGBTQ
- [ ] Other: _____

E. Perspective:

- [x] Consumer
- [x] Family Member
- [ ] MH Contractor
- [ ] MH County Staff

5. My Primary Stakeholder Representation is:

Children and Youth

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Kathi McLaughlin

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [ ] Aging & Older Adults
- [x] Innovation
- [x] Housing
- [ ] Social Inclusion
- [ ] Suicide Prevention
- [x] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [x] Capital Facilities / IT
- [ ] Data

C. Ad Hoc Committees

- [x] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [ ] No
- [x] Yes. *Please Describe*:

Martinez Unified School District receives PEI funding under the "Youth Development" category for our "New Leaf" program.

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [x] Child & Advocacy Task Force (CATF)
- [ ] Human Services Alliance
- [ ] Mental Health Coalition
- [ ] MHC
- [ ] NAMI
- [ ] Union Affiliation
- [ ] Other: _____

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CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

1. Candidate Name: Susan Medlin

2. CPAW Member Since (mm/dd/yyyy): 10/2009

3. Candidate Statement: (***150 words maximum***. Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

I would like the opportunity to help strengthen direct client involvement in service planning and implementation. As CPAW works with mental health staff members to transform all our services to increase the impact to those most in need, I would like to help to bring more of our direct service recipients and their family members to the table. I would also like to ensure continuation of consumer input into the leadership process.

I am very proud of the MHSA stakeholder process that we have in this county. It reflects the ideals and principles of the MHSA, which emphasize the importance of consumer and family member leadership and diverse representation in the MHSA process. I think that having more of our direct service recipients and their family members at the table will help us stay focused on addressing local needs and increasing accessibility to high quality, recovery and resiliency-oriented services.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [ ] East Region
- [ ] West Region

B. Ethnicity:

- [ ] African-American
- [ ] Asian/Pacific Islander
- [x] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [ ] CSS – Children
- [x] CSS – TAY
- [x] CSS – Adult
- [x] CSS – Older Adult
- [x] PEI – 0-25
- [x] PEI 26+
- [x] WE&T
- [ ] Capital Facilities/ IT

D. Community:

- [ ] Education
- [ ] Faith
- [ ] Health Provider
- [ ] Veterans
- [ ] Law Enforcement
- [ ] LGBTQ
- [x] Other: Recovery

E. Perspective:

- [x] Consumer
- [ ] Family Member
- [ ] MH Contractor
- [x] MH County Staff

5. My Primary Stakeholder Representation is:

CCMH Clients

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Susan Medlin

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- ☐ Planning
- ☐ Aging & Older Adults
- ☑ Innovation
- ☑ Housing
- ☑ Social Inclusion
- ☐ Suicide Prevention
- ☑ Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- ☑ Capital Facilities / IT
- ☑ Data

C. Ad Hoc Committees

- ☐ Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- ☐ No
- ☑ Yes. *Please Describe*:

I work for Contra Costa Mental Health.

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- ☐ Child & Advocacy Task Force (CATF)
- ☐ Human Services Alliance
- ☐ Mental Health Coalition
- ☐ MHC
- ☑ NAMI
- ☐ Union Affiliation
- ☑ Other: California Network

THANK YOU

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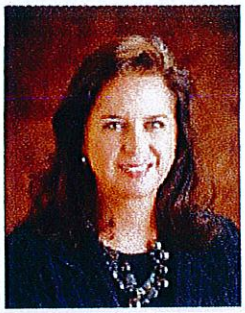
CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT



1. Candidate Name: Mariana Moore

2. CPAW Member Since (mm/dd/yyyy): 02/2009

3. Candidate Statement: (***150 words maximum***. Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

I would like to continue serving because I both offer value (through my understanding of and commitment to the system of care) and receive value (by learning from and working in partnership with other stakeholders). I understand our complex mental health delivery system; can shape and communicate the perspectives and ideas of community-based providers; am interested in being a bridge-builder and systems thinker; and have a history of building positive working relationships. As director of the Human Services Alliance, I serve on several county-wide stakeholder bodies and understand how to do so effectively. I am involved in the integration of mental health, AOD and homeless services under the new Behavioral Health Services umbrella, and will work to ensure that CPAW's voice is heard. On the Planning Committee, I will continue to support a culture of learning, transparency, compassion and accountability, to ensure we bring our best selves forward in service to those who need it most.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [x] East Region
- [x] West Region

B. Ethnicity:

- [ ] African-American
- [ ] Asian/Pacific Islander
- [x] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [x] CSS – Children
- [x] CSS – TAY
- [x] CSS – Adult
- [x] CSS – Older Adult
- [x] PEI – 0-25
- [x] PEI 26+
- [x] WE&T
- [x] Capital Facilities/ IT

D. Community:

- [ ] Education
- [ ] Faith
- [x] Health Provider
- [ ] Veterans
- [ ] Law Enforcement
- [ ] LGBTQ
- [x] Other: Community-based providers

E. Perspective:

- [ ] Consumer
- [ ] Family Member
- [x] MH Contractor
- [ ] MH County Staff

5. My Primary Stakeholder Representation is:

Community-based providers that partner with the county to provide services

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Mariana Moore

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [ ] Aging & Older Adults
- [ ] Innovation
- [ ] Housing
- [x] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [ ] Capital Facilities / IT
- [x] Data

C. Ad Hoc Committees

- [ ] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [x] No
- [ ] Yes. *Please Describe*:

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [x] Child & Advocacy Task Force (CATF)
- [x] Human Services Alliance
- [x] Mental Health Coalition
- [ ] MHC
- [ ] NAMI
- [ ] Union Affiliation
- [ ] Other: _____

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CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

1. Candidate Name: Teresa Pasquini

2. CPAW Member Since (mm/dd/yyyy): 03/2009

3. Candidate Statement: (***150 words maximum.*** Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

As a family member and advocate, I dream of an integrated system that will serve all of our most vulnerable which includes my first born child. The CPAW stakeholders are critical change agents as we navigate the tremendous shifts in our culture and health system. My dedication to a whole system improvement drives my commitment to CPAW and the Planning Committee. As a mental health commissioner I intersect and partner with all layers of stakeholders from the line staff, Board of Supervisors, Dr. Walker, Health Services Admin, law enforcement, labor, and community based organizations. Also my unique experience as a founding member of the Behavioral Healthcare Partnership at CCRMC has allowed me to develop strong alliances with primary care which creates a bridge from inpatient to outpatient. My focus as a Planning Committee member will be to act as a champion for system integration of the new Behavioral Health Division.

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

☐ Central Region ☐ East Region ☑ West Region

B. Ethnicity:

☐ African-American ☐ Asian/Pacific Islander ☑ Caucasian

☐ Hispanic / Latino ☐ Native American ☐ Other: _____

C. Program Area:

☐ CSS – Children ☐ CSS – TAY ☐ CSS – Adult ☐ CSS – Older Adult

☐ PEI – 0-25 ☑ PEI 26+ ☑ WE&T ☑ Capital Facilities/ IT

D. Community:

☐ Education ☐ Faith ☐ Health Provider ☐ Veterans

☐ Law Enforcement ☐ LGBTQ ☐ Other: _____

E. Perspective:

☐ Consumer ☑ Family Member ☐ MH Contractor ☐ MH County Staff

5. My Primary Stakeholder Representation is:

Family Member

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Teresa Pasquini

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [x] Planning
- [ ] Aging & Older Adults
- [ ] Innovation
- [ ] Housing
- [ ] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [x] Capital Facilities / IT
- [ ] Data

C. Ad Hoc Committees

- [ ] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [x] No
- [ ] Yes. *Please Describe*:

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [ ] Child & Advocacy Task Force (CATF)
- [ ] Human Services Alliance
- [x] Mental Health Coalition
- [x] MHC
- [x] NAMI
- [ ] Union Affiliation
- [x] Other: Behavioral Healthcare Partnership, CCRMC

THANK YOU

Save this document as your full name and return with a jpeg photo of yourself to:
Leigh Marz at leighmarz@sbcglobal.net
by Thursday, November 17, 2011, at Noon.

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

1. Candidate Name: Samuel S. Yoshioka

2. CPAW Member Since (mm/dd/yyyy): 06/2010

3. Candidate Statement: (***150 words maximum.*** Describe the reason you want to be on the Planning Committee. May include skills / abilities / experience / focus your membership will bring to the Planning Committee to help CPAW better fulfill its purpose)

EDUCATIONAL ACHIEVEMENTS:
(A) MBA and MPA - Health Services Management;
(B) NIMH Fellowship – Sociology of Medicine and Mental Health
WORK EXPERIENCES:
(A) Federal Grants: 1. Columbia Point Neighborhood Health Center (Boston, MA); 2. South of Market Neighborhood Health Center (SF, CA); 3. CCC West County Community Mental Health Center (Richmond, CA)
(B) Research: 1. Kaiser Foundation Hospital Research Division (Portland, OR); 2. UC School of Public Health (Berkeley, CA)
(C) CCC Health Services Department: 1. County Hospital Administrative Systems Coordinator; 2. Deputy Director West County Community Mental Health Center; 3. Health Services Administrator
VOLUNTEER EXPERIENCES:
(A) Alameda-Contra Costa Health Systems Agency
(B) AARP Foundation
(C) CA AARP Advocacy Team; CC Ombudsman Services; Lafayette-Orinda Presbyterian Church Thursday Fellowship; San Francisco Presbytery; CCC MHC; CCC MH Division CPAW and Standing Committees

4. Stakeholder Representation (check all that apply)

A. Contra Costa County Region:

- [x] Central Region
- [ ] East Region
- [ ] West Region

B. Ethnicity:

- [ ] African-American
- [x] Asian/Pacific Islander
- [ ] Caucasian
- [ ] Hispanic / Latino
- [ ] Native American
- [ ] Other: _____

C. Program Area:

- [ ] CSS – Children
- [ ] CSS – TAY
- [ ] CSS – Adult
- [ ] CSS – Older Adult
- [ ] PEI – 0-25
- [ ] PEI 26+
- [ ] WE&T
- [x] Capital Facilities/ IT

D. Community:

- [ ] Education
- [x] Faith
- [ ] Health Provider
- [x] Veterans
- [ ] Law Enforcement
- [ ] LGBTQ
- [ ] Other: AARP, Older Adults

E. Perspective:

- [ ] Consumer
- [x] Family Member
- [ ] MH Contractor
- [ ] MH County Staff

5. My Primary Stakeholder Representation is:

Mental Health Family Member

CPAW PLANNING COMMITTEE
CANDIDATE STATEMENT

Candidate Name (cont): Samuel S. Yoshioka

6. Past and Current Committee Membership (check all that apply)

A. Monthly Committees

- [✓] Planning
- [ ] Aging & Older Adults
- [ ] Innovation
- [ ] Housing
- [ ] Social Inclusion
- [ ] Suicide Prevention
- [ ] Membership (formerly Evaluation)

B. Standing Committees (As Needed)

- [✓] Capital Facilities / IT
- [✓] Data

C. Ad Hoc Committees

- [ ] Nomination

7. Conflict of Interest: Do you or the organization you work for receive or seek MHSA funding?

- [✓] No
- [ ] Yes. *Please Describe:*

8. Memberships or Affiliations with Related Groups:
(check all that apply)

- [ ] Child & Advocacy Task Force (CATF)
- [ ] Human Services Alliance
- [ ] Mental Health Coalition
- [✓] MHC
- [ ] NAMI
- [ ] Union Affiliation
- [ ] Other: AARP

THANK YOU

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Leigh Marz at leighmarz@sbcglobal.net
by Thursday, November 17, 2011, at Noon.

CPAW AGENDA ITEM
READINESS WORKSHEET

CPAW Meeting Date: Dec 1st 2011 **Name of Committee/ Individual**: Sandy Rose

1. **Agenda Item Name**: *CPAW Housing Committee Update*

2. **Desired Outcome**: *Informational*

3. **Brief Summary:** To provide an update of the CPAW Housing Committee's activities which includes but is not limited to working with the Mental Health Housing Service Coordinator, supporting new MHSA Housing developments, coordinating access to available housing, supporting board and care communities. Robin Lane Project in Concord Collaboration with affordable housing associates. Restructuring Housing Committee meeting structure.

4. **Specific Recommendation** *(if applicable)*: ***NA***

5. **Background:** There was a recommendation made that a CPAW Housing Committee member update be provided to CPAW quarterly.

6. **Funding Considerations**[1]: If this item includes funding, please answer the following relevant questions-
- What funding category does this item fall under?
- In that category, how much money has already been spent? How much remains?
- How much would this proposal cost (with as much precision as can be offered)?
- What other proposals are pending in this category and what are their associated costs?
- What proportion of the funding category would this program represent?
- Is there any other important funding context needed (eg. Reversion deadlines)?

CPAW Role: To receive the update provided by the CPAW Housing Committee representative.

Choose from the following[2]: Receive
- **Receive-** Increase understanding

7. **Other Important Factors:**
- Who else is influencing this item?
- Is there an upcoming deadline?
- Is "Conflict of Interest" a factor that should be acknowledged with this item?

8. **Anticipated Time Needed on Agenda:** 15 minutes

9. **Who will report on this item?** Sandy Rose

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[1] Please offer visual representations when possible.
[2] Please note that the levels of engagement are in ascending order- from lesser to greater levels -of engagement. The greater the level of engagement, the more background and context should be provided by the committee.

CONTRA COSTA
HEALTH SERVICES

Charter of the Consolidated Planning Advisory Workgroup

Approved July 16, 2009

Background

The California Department of Mental Health mandates that a Community Program Planning Process (CPP) serve as the basis for all Mental Health Services Act (MHSA) Planning. To date, there have been multiple MHSA Stakeholder Workgroups in Contra Costa, including: Community Services & Supports, Prevention & Early Intervention, Workforce Education & Training, and Capital Facilities & Information Technology.

The next major planning phase for MHSA in Contra Costa Mental Health (CCMH) is to develop an integrated 3-year plan for all components of MHSA that updates the existing plans, improves their quality, and integrates them into a single planning cycle. CCMH intends to submit its integrated plan to the State Department of Mental Health in April 2010.

The framework for the Integrated Plan consists of five sections:

1. Community Planning Process
2. Community vision and three year goals
3. Report on prior year's MHSA activities
4. Funding request summary for the upcoming year
5. Report of performance indicators

Purpose and Role of the Consolidated Planning Advisory Workgroup (CPAW)

The mission and purpose of the Consolidated Planning Advisory Workgroup (CPAW) is to assist CCMH with integrated planning, as well as to increase the transparency of MHSA efforts. Activities CPAW will be involved in include:

- Serving as the stakeholder group for the MHSA Innovation Component.
- Developing annual updates to existing MHSA plans: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities and Technology, etc.
- Developing an integrated, transformative vision for the CCMH system.
- Advising on integration of MHSA principles/practices into the larger MH system.

- Developing 3-year integrated plans and updates.
- Developing an assessment process for reviewing MHSA components (or building upon existing quality improvement processes in CCMH).
- Reviewing findings from the assessment process.
- Advising of funding opportunities.
- Serve as MHSA ambassadors to the larger community of Contra Costa County.

Goals (approved for six months through December 2009)

Goal I:
Develop an inclusive process to review, revise, recommend and monitor each component plan of MHSA (Community Services & Supports, Innovation, Capital Facilities, Technology, Work Force, Prevention and Early Intervention, PEI Technical Assistance).

Goal II:
Evaluate the qualitative and quantitative outcomes of individual MHSA Programs.

Goal III:
Create recommendations to policymakers for transforming the public/private mental health system in Contra Costa County.

Composition

Members of the CPAW were selected by the CCMH Director of Mental Health in February 2009 and will serve for at least one year. As members leave, every attempt will be made to replace them with individuals with similar skills, knowledge and background. CPAW membership reflects new and past stakeholder involvement, as well as diversity in ethnicity and culture, consumer, family, MH provider, education, health, social services, law, faith, regional representation, etc.

The Mental Health Director would like to maintain the composition at the current level, which is as follows:

Category Represented	Number Required
Previous CSS-Children Stakeholder	2
Previous CSS TAY Stakeholder	2
Previous CSS Adult Stakeholder	2

Previous CSS Older Adult Stakeholder	2
Previous PEI 0–25 Stakeholder	2
Previous PEI 26+ Stakeholder	2
Previous WE&T Stakeholder	2
Previous Capital Facilities Stakeholder	2
Previous IT Stakeholder	2
Not a Previous MHSA Stakeholder	7
Youth Representative (age 14–18)	1
Transition Age Youth Representative (age 18–25)	1
TOTAL MEMBERSHIP:	**27**

Representation for Above Seats Should Be Taken from the Following:

Mental Health Consumer	At least 25% of membership of CPAW must be mental health consumers.	
Mental Health Family Member	At least 25% of membership of CPAW must be mental health consumers.	
MH Provider, County		2
MH Provider, Contractor		2
Education/Schools		2
Social Services		1
Faith Community		1
Health Provider		1

Law Enforcement	1
Mental Health Commission	1
Also Select for the Following:	
West Region Representative	2
Central Region Representative	2
East Region Representative	2
Native American	2
African American	4
Hispanic/Latino	4
Asian/Pacific Islander	2
LGBTQ	2

Only those members as appointed by the Mental Health Director to one of the representative groups noted, above, will be allowed to vote on items that require action by CPAW. Some members of CPAW may also be County staff, however, they are representing one of the stakeholder interests as noted, above.

Sherry Bradley will serve as the Convener of CPAW meetings. Other CCMH and/or MHSA staff and consultants will serve as resources to the CPAW, but will not be voting members of CPAW.

Schedule

Meetings are most effective when, from the outset, the group has clear expectations for participation and agreement regarding how the meetings will be run. The following preliminary groundrules have been reviewed, finalized, and adopted by the CPAW to ensure that its meetings are engaging, open, collaborative, efficient, and effective:

Ground Rules

Meetings are most effective when, from the outset, the group has clear expectations for participation and agreement regarding how the meetings will be run. The following preliminary groundrules have been reviewed, finalized, and adopted by the CPAW to ensure that its meetings are engaging, open, collaborative, efficient, and effective:

1. Agendas and minutes of the previous meeting will be emailed before each meeting

2. Meetings will start and stop on time.
3. One speaker at a time; allow the facilitator to "direct traffic."
4. Speaker's remarks should be brief to allow for others to speak.
5. Listen to and value other points of view, even if they differ from yours.
6. To the greatest extent possible, system interests should trump personal interests.
7. Declare potential conflicts of interest before the topic is discussed.
8. Focus on past stakeholder processes only to the extent that it helps the CPAW move forward.
9. When the group makes a decision, seek consensus first; a simple majority is the second option.
10. Turn off cell phones, unless your job requires you to be readily available.

Conclusion

The CPAW is comprised of individuals who believe in the values and principles inherent in the MHSA and who actively support CCMH's plan inside the CCMH organization and in the community. The CPAW maintains a high standard of excellence for itself and for all those participating in the MHSA process. For members of the CPAW this is a significant responsibility that calls for active participation, clear expectations, high performance, and outcomes that support the goals of CCMH's MHSA plans.

Content provided by Contra Costa County Mental Health Division of Contra Costa Health Services.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions

§ 3200.050. Client Driven.

"Client Driven" means that the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Sections 5813.5(d)(2): Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(2) To promote consumer-operated services as a way to support recovery.

Section 5830(a)(2): 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:

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

Section 5866: (a) Counties shall develop a method to encourage interagency collaboration with shared responsibility for services and the client and cost outcome goals.

(b) The local mental health director shall form or facilitate the formation of a county interagency policy and planning committee. The members of the council shall include, but not be limited to, family members of children who have been or are currently being served in the county mental health system and the leaders of participating local government agencies, to include a member of the board of supervisors, a juvenile court judge, the district attorney, the public defender, the county counsel, the superintendent of county schools, the public social services director, the chief probation officer, and the mental health director.

(c) The duties of the committee shall include, but not be limited to, all of the following:

(1) Identifying those agencies that have a significant joint responsibility for the target population and ensuring collaboration on countywide planning and policy.

(2) Identifying gaps in services to members of the target population, developing policies to ensure service effectiveness and continuity, and setting priorities for interagency services.

(3) Implementing public and private collaborative programs whenever possible to better serve the target population.

(d) The local mental health director shall form or facilitate the formation of a countywide interagency case management council whose function shall be to coordinate resources to specific target population children who are using the services of more than one agency concurrently. The members of this council shall include, but not be limited to, representatives from the local special education, juvenile probation, children's social services, and mental health services agencies, with necessary authority to commit resources from their agency to an interagency service plan for a child and family. The roles, responsibilities, and operation of these councils shall be specified in written interagency agreements or memoranda of understanding, or both.

(e) The local mental health director shall develop written interagency agreements or memoranda of understanding with the agencies listed in this subdivision, as necessary. Written interagency agreements or memoranda shall specify jointly provided or integrated services, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services. The agreements shall be reviewed and updated annually.

(f) The agreements required by subdivision (e) may be established with any of the following:

(1) Special education local planning area consortiums.

(2) The court juvenile probation department.

(3) The county child protective services agency.

(4) The county public health department.

(5) The county department of drug and alcohol services.

(6) Other local public or private agencies serving children.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions

§ 3200.060. Community Collaboration.

"Community Collaboration" means a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5830(a)(3): 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:

(3) To promote interagency collaboration.

Section 5866: (a) Counties shall develop a method to encourage interagency collaboration with shared responsibility for services and the client and cost outcome goals.

(b) The local mental health director shall form or facilitate the formation of a county interagency policy and planning committee. The members of the council shall include, but not be limited to, family members of children who have been or are currently being served in the county mental health system and the leaders of participating local government agencies, to include a member of the board of supervisors, a juvenile court judge, the district attorney, the public defender, the county counsel, the superintendent of county schools, the public social services director, the chief probation officer, and the mental health director.

(c) The duties of the committee shall include, but not be limited to, all of the following:

(1) Identifying those agencies that have a significant joint responsibility for the target population and ensuring collaboration on countywide planning and policy.

(2) Identifying gaps in services to members of the target population, developing policies to ensure service effectiveness and continuity, and setting priorities for interagency services.

(3) Implementing public and private collaborative programs whenever possible to better serve the target population.

(d) The local mental health director shall form or facilitate the formation of a countywide interagency case management council whose function shall be to coordinate resources to specific target population children who are using the services of more than one agency concurrently. The members of this council shall include, but not be limited to, representatives from the local special education, juvenile probation, children's social services, and mental health services agencies, with necessary authority to commit resources from their agency to an interagency service plan for a child and family. The roles, responsibilities, and operation of these councils shall be specified in written interagency agreements or memoranda of understanding, or both.

(e) The local mental health director shall develop written interagency agreements or memoranda of understanding with the agencies listed in this subdivision, as necessary. Written interagency agreements or memoranda shall specify jointly provided or integrated services, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services. The agreements shall be reviewed and updated annually.

(f) The agreements required by subdivision (e) may be established with any of the following:

(1) Special education local planning area consortiums.

(2) The court juvenile probation department.

(3) The county child protective services agency.

(4) The county public health department.

(5) The county department of drug and alcohol services.
(6) Other local public or private agencies serving children.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions
§ 3200.070. Community Program Planning Process.

"Community Program Planning" means the process to be used by the County to develop Three-Year Program and Expenditure Plans, and updates in partnership with stakeholders to:

(1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act.

(2) Analyze the mental health needs in the community.

(3) Identify and re-evaluate priorities and strategies to meet those mental health needs.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 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.
(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

Section 5892. (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.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions
§ 3200.080. Community Services and Supports.

"Community Services and Supports" means the component of the Three-Year Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code Sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care).

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5847. Integrated Plans for Prevention, Innovation, and System of Care Services.
(a) It is the intent of the Legislature to streamline the approval processes of the State Department of Mental Health and the Mental Health Services Oversight and Accountability Commission of programs developed pursuant to Sections 5891 and 5892.
(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).

Section 5847. Integrated Plans for Prevention, Innovation, and System of Care Services.
(c) The State Department of Mental Health shall not issue guidelines for the Integrated Plans for Prevention, Innovation, and System of Care Services before January 1, 2012.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act

Article 2. Definitions

§ 3200.090. County.

"County" means the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per Welfare and Institutions Code Section 5701.5.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5897. (a) Notwithstanding any other provision of state law, the State Department of Mental Health 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 Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 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 of the anticipated

county matching funds needed for community mental health programs.

Section 5701. (a) To achieve equity of funding, available funding for local mental health programs beyond the funding provided pursuant to Section 17601 shall be distributed to cities, counties, and cities and counties pursuant to the procedures described in subdivision (c) of Section 17606.05.

(b) Funding provided pursuant to Section 6 of Article XIII B of the California Constitution, funding provided pursuant to subdivision (c), and funding provided for future pilot projects shall be exempt from the requirements of subdivision (a).

(c) Effective in the 1994-95 fiscal year and each year thereafter:

(1) The State Department of Mental Health shall annually identify from mental health block grant funds provided by the federal government, the maximum amount that federal law and regulation permit to be allocated to counties and cities and counties pursuant to this subdivision. This section shall apply to any federal mental health block grant funds in excess of the following:

(A) The amount allocated to counties and cities and counties from the alcohol, drug abuse, and mental health block grant in the 1991-92 fiscal year.

(B) Funds for departmental support.

(C) Amounts awarded to counties and cities and counties for children's systems of care programs pursuant to Part 4 (commencing with Section 5850).

(D) Amounts allocated to small counties for the development of alternatives to state hospitalization in the 1993-94 fiscal year.

(E) Amounts appropriated by the Legislature for the purposes of this part.

(2) Notwithstanding subdivision (a), annually the State Department of Mental Health shall allocate to counties and cities and counties the funds identified in paragraph (1), not to exceed forty million dollars ($40,000,000) in any year. The allocations shall be proportional to each county's and each city and county's percentage of the forty million dollars ($40,000,000) in Cigarette and Tobacco Products Surtax funds that were allocated to local mental health programs in the 1991-92 fiscal year.

(3) Monthly, the Controller shall allocate funds from the Vehicle License Collection Account of the Local Revenue Fund to counties and cities and counties for mental health services. Allocations shall be made to each county or city and county in the same percentages as described in paragraph (2), until the total of the funds allocated to all counties in each year pursuant to paragraph (2) and this paragraph reaches forty million dollars ($40,000,000).

(4) Funds allocated to counties and cities and counties pursuant to paragraphs (2) and (3) shall not be subject to Section 17606.05.

(5) Funds that are available for allocation in any year in excess of the forty million dollar ($40,000,000) limits described in paragraph (2) or (3) shall be deposited into the Mental Health Subaccount of the Local Revenue Fund.

(6) Nothing in this section is intended to, nor shall it, change the base allocation of any city, county, or city and county as provided in Section 17601.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions
§ 3200.100. Cultural Competence.

"Cultural Competence" means incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

(1) Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.

(2) Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.

(3) Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.

(4) An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.

(5) An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.

(6) An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.

(7) Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.

(8) Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.

(9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 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.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

Section 5868. (a) The department shall establish service standards that ensure that children in the target population are identified and receive needed and appropriate services from qualified staff in the least restrictive environment.

(b) The standards shall include, but not be limited to:

(1) Providing a comprehensive assessment and treatment plan for each target population client to be served, and developing programs and services that will meet their needs and facilitate client outcome goals.

(2) Providing for full participation of the family in all aspects of assessment, case planning, and treatment.

(3) Providing methods of assessment and services to meet the cultural, linguistic, and special needs of minorities in the target population.

(4) Providing for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services resulting from a limited ability to speak English or from cultural differences.

(5) Providing mental health case management for all target population clients in, or being considered for, out-of-home placement.

(6) Providing mental health services in the natural environment of the child to the extent feasible and appropriate.

Section 5878. (a) (1) The Secretary of the Health and Welfare Agency, the Superintendent of Public Instruction, or the Secretary of the Youth and Corrections Agency may waive any state regulatory obstacles to the integration of public responsibilities and resources required for counties which have been approved as system of care counties.
(2) The waiver shall remain in effect as long as the local program continues to meet standards as specified in the scope of work plan approved by the State Department of Mental Health.

(b) The Secretary of Health and Welfare, the Superintendent of Public Instruction, and the Secretary of the Youth and Corrections Agency, and those departments designated as single state agencies administering federal programs, shall make every effort to secure federal waivers and any other changes in federal policy or law necessary to support interagency collaboration and coordination in a system of care service delivery system.

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§ 3200.110. Department.

"Department" means the State Department of Mental Health.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 4001. As used in this division:
(a) "Department" means the State Department of Mental Health.
(b) "Director" means the Director of Mental Health.
(c) "State hospital" means any hospital specified in Section 4100.

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§ 3200.120. Family Driven.

"Family Driven" means that families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5822. The State Department of Mental Health shall include in the five-year plan:
(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.
(b) Expansion plans for the forgiveness and scholarship programs

offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, master's degrees, or doctoral degrees.

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

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

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

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of 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.

(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).

Section 5840. (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.

Section 5868. (a) The department shall establish service standards that ensure that children in the target population are identified and receive needed and appropriate services from qualified staff in the least restrictive environment.

(b) The standards shall include, but not be limited to:

(1) Providing a comprehensive assessment and treatment plan for each target population client to be served, and developing programs and services that will meet their needs and facilitate client outcome goals.

(2) Providing for full participation of the family in all aspects of assessment, case planning, and treatment.

Section 5878.1. (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to

severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

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

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§ 3200.125. Financial Incentive Programs Funding Category.

"Financial Incentive Programs Funding Category" means the funding category of the Workforce Education and Training component of the Three-Year Program and Expenditure Plan that funds stipends, scholarships and the Mental Health Loan Assumption Program for the purpose of recruiting and retaining Public Mental Health System employees.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

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

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

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

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

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

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

programs, and increasing the number of human service academies.
(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of 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.
(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).

Section 5840. (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.

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§ 3200.130. Full Service Partnership.

"Full Service Partnership" means the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5801. (a) A system of care for adults and older adults with severe mental illness results in the highest benefit to the client, family, and community while ensuring that the public sector meets its legal responsibility and fiscal liability at the lowest possible cost.
(b) The underlying philosophy for these systems of care includes the following:
(1) Mental health care is a basic human service.
(2) Seriously mentally disordered adults and older adults are citizens of a community with all the rights, privileges, opportunities, and responsibilities accorded other citizens.
(3) Seriously mentally disordered adults and older adults usually have multiple disorders and disabling conditions and should have the highest priority among adults for mental health services.
(4) Seriously mentally disordered adults and older adults should have an interagency network of services with multiple points of access and be assigned a single person or team to be responsible for

all treatment, case management, and community support services.

(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment.

(6) Clients and families should directly participate in making decisions about services and resource allocations that affect their lives.

(7) People in local communities are the most knowledgeable regarding their particular environments, issues, service gaps and strengths, and opportunities.

(8) Mental health services should be responsive to the unique characteristics of people with mental disorders including age, gender, minority and ethnic status, and the effect of multiple disorders.

(9) For the majority of seriously mentally disordered adults and older adults, treatment is best provided in the client's natural setting in the community. Treatment, case management, and community support services should be designed to prevent inappropriate removal from the natural environment to more restrictive and costly placements.

(10) Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.

(11) State and county government agencies each have responsibilities and fiscal liabilities for seriously mentally disordered adults and seniors.

Section 5802. (a) The Legislature finds that a mental health system of care for adults and older adults with severe and persistent mental illness is vital for successful management of mental health care in California. Specifically:

(1) A comprehensive and coordinated system of care includes community-based treatment, outreach services and other early intervention strategies, case management, and interagency system components required by adults and older adults with severe and persistent mental illness.

(2) Mentally ill adults and older adults receive service from many different state and county agencies, particularly criminal justice, employment, housing, public welfare, health, and mental health. In a system of care these agencies collaborate in order to deliver integrated and cost-effective programs.

(3) The recovery of persons with severe mental illness and their financial means are important for all levels of government, business, and the community.

(4) System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes.

(5) Mental health service providers need to increase accountability and further develop methods to measure progress towards client outcome goals and cost effectiveness as required by a system of care.

(b) The Legislature further finds that the adult system of care model, beginning in the 1989-90 fiscal year through the implementation of Chapter 982 of the Statutes of 1988, provides

models for adults and older adults with severe mental illness that can meet the performance outcomes required by the Legislature.

(c) The Legislature also finds that the system components established in adult systems of care are of value in providing greater benefit to adults and older adults with severe and persistent mental illness at a lower cost in California.

(d) Therefore, using the guidelines and principles developed under the demonstration projects implemented under the adult system of care legislation in 1989, it is the intent of the Legislature to accomplish the following:

(1) Encourage each county to implement a system of care as described in this legislation for the delivery of mental health services to seriously mentally disordered adults and older adults.

(2) To promote system of care accountability for performance outcomes which enable adults with severe mental illness to reduce symptoms which impair their ability to live independently, work, maintain community supports, care for their children, stay in good health, not abuse drugs or alcohol, and not commit crimes.

(3) Maintain funding for the existing pilot adult system of care programs that meet contractual goals as models and technical assistance resources for future expansion of system of care programs to other counties as funding becomes available.

(4) Provide funds for counties to establish outreach programs and to provide mental health services and related medications, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and other nonmedical programs necessary to stabilize homeless mentally ill persons or mentally ill persons at risk of being homeless, get them off the street, and into treatment and recovery, or to provide access to veterans' services that will also provide for treatment and recovery.

Section 5850. This part shall be known and may be cited as the Children's Mental Health Services Act.

Section 5866. (a) Counties shall develop a method to encourage interagency collaboration with shared responsibility for services and the client and cost outcome goals.

(b) The local mental health director shall form or facilitate the formation of a county interagency policy and planning committee. The members of the council shall include, but not be limited to, family members of children who have been or are currently being served in the county mental health system and the leaders of participating local government agencies, to include a member of the board of supervisors, a juvenile court judge, the district attorney, the public defender, the county counsel, the superintendent of county schools, the public social services director, the chief probation officer, and the mental health director.

(c) The duties of the committee shall include, but not be limited to, all of the following:

(1) Identifying those agencies that have a significant joint responsibility for the target population and ensuring collaboration on countywide planning and policy.

(2) Identifying gaps in services to members of the target population, developing policies to ensure service effectiveness and continuity, and setting priorities for interagency services.

(3) Implementing public and private collaborative programs whenever possible to better serve the target population.

(d) The local mental health director shall form or facilitate the formation of a countywide interagency case management council whose function shall be to coordinate resources to specific target population children who are using the services of more than one agency concurrently. The members of this council shall include, but not be limited to, representatives from the local special education, juvenile probation, children's social services, and mental health services agencies, with necessary authority to commit resources from their agency to an interagency service plan for a child and family. The roles, responsibilities, and operation of these councils shall be specified in written interagency agreements or memoranda of understanding, or both.

(e) The local mental health director shall develop written interagency agreements or memoranda of understanding with the agencies listed in this subdivision, as necessary. Written interagency agreements or memoranda shall specify jointly provided or integrated services, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services. The agreements shall be reviewed and updated annually.

(f) The agreements required by subdivision (e) may be established with any of the following:

(1) Special education local planning area consortiums.

(2) The court juvenile probation department.

(3) The county child protective services agency.

(4) The county public health department.

(5) The county department of drug and alcohol services.

(6) Other local public or private agencies serving children.

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§ 3200.140. Full Service Partnership Service Category.

"Full Service Partnership Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

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

(a) It is the intent of the Legislature to streamline the approval processes of the State Department of Mental Health and the Mental Health Services Oversight and Accountability Commission of programs

developed pursuant to Sections 5891 and 5892.

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

(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.

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§ 3200.150. Full Spectrum of Community Services.

"Full Spectrum of Community Services" means the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5801. (b) The underlying philosophy for these systems of care includes the following:

(1) Mental health care is a basic human service.

(2) Seriously mentally disordered adults and older adults are citizens of a community with all the rights, privileges, opportunities, and responsibilities accorded other citizens.

(3) Seriously mentally disordered adults and older adults usually have multiple disorders and disabling conditions and should have the highest priority among adults for mental health services.

(4) Seriously mentally disordered adults and older adults should have an interagency network of services with multiple points of access and be assigned a single person or team to be responsible for all treatment, case management, and community support services.

(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment.

(6) Clients and families should directly participate in making decisions about services and resource allocations that affect their lives.

(7) People in local communities are the most knowledgeable regarding their particular environments, issues, service gaps and strengths, and opportunities.

(8) Mental health services should be responsive to the unique characteristics of people with mental disorders including age, gender, minority and ethnic status, and the effect of multiple disorders.

(9) For the majority of seriously mentally disordered adults and older adults, treatment is best provided in the client's natural setting in the community. Treatment, case management, and community support services should be designed to prevent inappropriate removal from the natural environment to more restrictive and costly placements.

(10) Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.

(11) State and county government agencies each have responsibilities and fiscal liabilities for seriously mentally disordered adults and seniors.

Section 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.

(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.

Section 5851. (a) The Legislature finds and declares that there is no comprehensive county interagency system throughout California for the delivery of mental health services to seriously emotionally and behaviorally disturbed children and their families. Specific problems to be addressed include the following:

(1) The population of children which should receive highest priority for services has not been defined.

(2) Clear and objective client outcome goals for children receiving services have not been specified.

(3) Although seriously emotionally and behaviorally disturbed children usually have multiple disabilities, the many different state and county agencies, particularly education, social services, juvenile justice, health, and mental health agencies, with shared responsibility for these individuals, do not always collaborate to develop and deliver integrated and cost-effective programs.

(4) A range of community-based treatment, case management, and interagency system components required by children with serious

emotional disturbances has not been identified and implemented.

(5) Service delivery standards that ensure culturally competent care in the most appropriate, least restrictive environment have not been specified and required.

(6) The mental health system lacks accountability and methods to measure progress towards client outcome goals and cost-effectiveness. There are also no requirements for other state and county agencies to collect or share relevant data necessary for the mental health system to conduct this evaluation.

(b) The Legislature further finds and declares that the model developed in Ventura County beginning in the 1984-85 fiscal year through the implementation of Chapter 1474 of the Statutes of 1984 and expanded to the Counties of Santa Cruz, San Mateo, and Riverside in the 1989-90 fiscal year pursuant to Chapter 1361 of the Statutes of 1987, provides a comprehensive, interagency system of care for seriously emotionally and behaviorally disturbed children and their families and has successfully met the performance outcomes required by the Legislature. The Legislature finds that this accountability for outcome is a defining characteristic of a system of care as developed under this part. It finds that the system established in these four counties can be expanded statewide to provide greater benefit to children with serious emotional and behavioral disturbances at a lower cost to the taxpayers. It finds further that substantial savings to the state and these four counties accrue annually, as documented by the independent evaluator provided under this part. Of the amount continuing to be saved by the state in its share of out-of-home placement costs and special education costs for those counties and others currently funded by this part, a portion is hereby reinvested to expand and maintain statewide the system of care for children with serious emotional and behavioral disturbances.

(c) Therefore, using the Ventura County model guidelines, it is the intent of the Legislature to accomplish the following:

(1) To phase in the system of care for children with serious emotional and behavioral problems developed under this part to all counties within the state.

(2) To require that 100 percent of the new funds appropriated under this part be dedicated to the targeted population as defined in Sections 5856 and 5856.2. To this end, it is the intent of the Legislature that families of eligible children be involved in county program planning and design and, in all cases, be involved in the development of individual child treatment plans.

(3) To expand interagency collaboration and shared responsibility for seriously emotionally and behaviorally disturbed children in order to do the following:

(A) Enable children to remain at home with their families whenever possible.

(B) Enable children placed in foster care for their protection to remain with a foster family in their community as long as separation from their natural family is determined necessary by the juvenile court.

(C) Enable special education pupils to attend public school and make academic progress.

(D) Enable juvenile offenders to decrease delinquent behavior.

(E) Enable children requiring out-of-home placement in licensed residential group homes or psychiatric hospitals to receive that care in as close proximity as possible to the child's usual residence.

(F) Separately identify and categorize funding for these services.

(4) To increase accountability by expanding the number of counties with a performance contract that requires measures of client outcome and cost avoidance.

(d) It is the intent of the Legislature that the outcomes prescribed by this section shall be achieved regardless of the cultural or ethnic origin of the seriously emotionally and behaviorally disturbed children and their families.

Section 5868. (b) The standards shall include, but not be limited to:

(2) Providing for full participation of the family in all aspects of assessment, case planning, and treatment.

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§ 3200.160. Fully Served.

"Fully Served" means clients, and their family members who obtain mental health services, receive the full spectrum of community services and supports needed to advance the client's recovery, wellness and resilience.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5801. (b) The underlying philosophy for these systems of care includes the following:

(1) Mental health care is a basic human service.

(2) Seriously mentally disordered adults and older adults are citizens of a community with all the rights, privileges, opportunities, and responsibilities accorded other citizens.

(3) Seriously mentally disordered adults and older adults usually have multiple disorders and disabling conditions and should have the highest priority among adults for mental health services.

(4) Seriously mentally disordered adults and older adults should have an interagency network of services with multiple points of access and be assigned a single person or team to be responsible for all treatment, case management, and community support services.

(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment.

(6) Clients and families should directly participate in making decisions about services and resource allocations that affect their lives.

(7) People in local communities are the most knowledgeable regarding their particular environments, issues, service gaps and strengths, and opportunities.

(8) Mental health services should be responsive to the unique characteristics of people with mental disorders including age, gender, minority and ethnic status, and the effect of multiple disorders.

(9) For the majority of seriously mentally disordered adults and older adults, treatment is best provided in the client's natural setting in the community. Treatment, case management, and community support services should be designed to prevent inappropriate removal from the natural environment to more restrictive and costly placements.

(10) Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.

(11) State and county government agencies each have responsibilities and fiscal liabilities for seriously mentally disordered adults and seniors.

Section 5806. The State Department of Mental Health shall establish service standards that ensure that members of the target population are identified, and services provided to assist them to live independently, work, and reach their potential as productive citizens. The department shall provide annual oversight of grants issued pursuant to this part for compliance with these standards. These standards shall include, but are not limited to, all of the following:

(a) A service planning and delivery process that is target population based and includes the following:

(1) Determination of the numbers of clients to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.

(2) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans also shall contain evaluation strategies, that shall consider cultural, linguistic, gender, age, and special needs of minorities in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services due to limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.

(3) Provision for services to meet the needs of target population clients who are physically disabled.

(4) Provision for services to meet the special needs of older

adults.

(5) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate for the individual.

(6) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles.

(7) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.

(8) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated due to age.

(9) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

(10) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

(11) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services but are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs.

(12) Provision for services for veterans.

(b) A client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and followthrough of services, and necessary advocacy to ensure that the client receives those services that are agreed to in the personal services plan. A client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, consult with the family and other significant persons as appropriate.

(c) The individual personal services plan shall ensure that members of the target population involved in the system of care receive age-appropriate, gender-appropriate, and culturally appropriate services or appropriate services based on any characteristic listed or defined in Section 11135 of the Government Code, to the extent feasible, that are designed to enable recipients to:

(1) Live in the most independent, least restrictive housing feasible in the local community, and for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(2) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(3) Create and maintain a support system consisting of friends, family, and participation in community activities.

(4) Access an appropriate level of academic education or vocational training.

(5) Obtain an adequate income.

(6) Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(7) Access necessary physical health care and maintain the best possible physical health.

(8) Reduce or eliminate serious antisocial or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system.

(9) Reduce or eliminate the distress caused by the symptoms of mental illness.

(10) Have freedom from dangerous addictive substances.

(d) The individual personal services plan shall describe the service array that meets the requirements of subdivision (c), and to the extent applicable to the individual, the requirements of subdivision (a).

Section 5852. There is hereby established an interagency system of care for children with serious emotional and behavioral disturbances that provides comprehensive, coordinated care based on the demonstration project under former Chapter 7 (commencing with Section 5575), as added by Chapter 160 of the Statutes of 1987, and the 1983 State Department of Mental Health planning model for children's services. Each participating county shall adapt the model to local needs and priorities.

Section 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.

(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.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions

§ 3200.170. General System Development Service Category.

"General System Development Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans under which the County uses Mental Health Services Act funds to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

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

Section 5847. Integrated Plans for Prevention, Innovation, and System of Care Services.
(a) It is the intent of the Legislature to streamline the approval processes of the State Department of Mental Health and the Mental Health Services Oversight and Accountability Commission of programs developed pursuant to Sections 5891 and 5892.
(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).

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions
§ 3200.180. Individual Services and Supports Plan.

"Individual Services and Supports Plan" means the plan developed by the client and, when appropriate the client's family, with the Personal Service Coordinator/Case Manager to identify the client's goals and describe the array of services and supports necessary to advance these goals based on the client's needs and preferences and, when appropriate, the needs and preferences of the client's family.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5699.4. On and after January 1, 1987, any county may provide case management services for children with serious emotional disturbance pursuant to this chapter. The case management services may include all of the following:
(a) Development of an individual treatment plan for each child. The plan shall be collaboratively prepared and reviewed and modified, if necessary, at least annually, by one representative of the mental health program, the parents, legal guardian, conservator, or court appointed social worker or probation officer, and, where appropriate, the minor.
(b) Assignment of a mental health case manager to each child. The duties of the mental health case manager may include, but not be limited to, all of the following:
(1) Coordinating an ecological assessment of the child's needs which evaluates the child both individually and in relation to his or her family, school, and community environments.
(2) Developing, implementing, monitoring, and reviewing each individual treatment plan that addresses the identified needs.
(3) Linking and arranging or providing for the needed services.
(4) Monitoring the adequacy of the services provided.
(5) Advocating for the minor.

Section 5806. The State Department of Mental Health shall establish service standards that ensure that members of the target population are identified, and services provided to assist them to live independently, work, and reach their potential as productive citizens. The department shall provide annual oversight of grants issued pursuant to this part for compliance with these standards. These standards shall include, but are not limited to, all of the following:
(b) A client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed

services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and followthrough of services, and necessary advocacy to ensure that the client receives those services that are agreed to in the personal services plan. A client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, consult with the family and other significant persons as appropriate.

(c) The individual personal services plan shall ensure that members of the target population involved in the system of care receive age-appropriate, gender-appropriate, and culturally appropriate services or appropriate services based on any characteristic listed or defined in Section 11135 of the Government Code, to the extent feasible, that are designed to enable recipients to:

(1) Live in the most independent, least restrictive housing feasible in the local community, and for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(2) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(3) Create and maintain a support system consisting of friends, family, and participation in community activities.

(4) Access an appropriate level of academic education or vocational training.

(5) Obtain an adequate income.

(6) Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(7) Access necessary physical health care and maintain the best possible physical health.

(8) Reduce or eliminate serious antisocial or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system.

(9) Reduce or eliminate the distress caused by the symptoms of mental illness.

(10) Have freedom from dangerous addictive substances.

(d) The individual personal services plan shall describe the service array that meets the requirements of subdivision (c), and to the extent applicable to the individual, the requirements of subdivision (a).

Section 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.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(4) To plan for each consumer's individual needs.

Section 5868. (a) The department shall establish service standards that ensure that children in the target population are identified and receive needed and appropriate services from qualified staff in the least restrictive environment.

(b) The standards shall include, but not be limited to:

(1) Providing a comprehensive assessment and treatment plan for each target population client to be served, and developing programs and services that will meet their needs and facilitate client outcome goals.

(2) Providing for full participation of the family in all aspects of assessment, case planning, and treatment.

(3) Providing methods of assessment and services to meet the cultural, linguistic, and special needs of minorities in the target population.

(4) Providing for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services resulting from a limited ability to speak English or from cultural differences.

(5) Providing mental health case management for all target population clients in, or being considered for, out-of-home placement.

(6) Providing mental health services in the natural environment of the child to the extent feasible and appropriate.

(c) The responsibility of the case managers shall be to ensure that each child receives the following services:

(1) A comprehensive mental health assessment.

(2) Case planning with all appropriate interagency participation.

(3) Linkage with all appropriate mental health services.

(4) Service plan monitoring.

(5) Client advocacy to ensure the provision of needed services.

Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 2. Definitions

§ 3200.190. Integrated Service Experience.

"Integrated Service Experience" means the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner.

Note: Authority cited Welfare & Institutions Code:

Section 5898, Welfare and Institutions Code: The state shall develop regulations, as necessary, for the State Department of Mental Health, 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.

Section 5878.1. (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to

severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

Section 5802. (a) The Legislature finds that a mental health system of care for adults and older adults with severe and persistent mental illness is vital for successful management of mental health care in California. Specifically:

(1) A comprehensive and coordinated system of care includes community-based treatment, outreach services and other early intervention strategies, case management, and interagency system components required by adults and older adults with severe and persistent mental illness.

(2) Mentally ill adults and older adults receive service from many different state and county agencies, particularly criminal justice, employment, housing, public welfare, health, and mental health. In a system of care these agencies collaborate in order to deliver integrated and cost-effective programs.

(3) The recovery of persons with severe mental illness and their financial means are important for all levels of government, business, and the community.

(4) System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes.

(5) Mental health service providers need to increase accountability and further develop methods to measure progress towards client outcome goals and cost effectiveness as required by a system of care.

(b) The Legislature further finds that the adult system of care model, beginning in the 1989-90 fiscal year through the implementation of Chapter 982 of the Statutes of 1988, provides models for adults and older adults with severe mental illness that can meet the performance outcomes required by the Legislature.

(c) The Legislature also finds that the system components established in adult systems of care are of value in providing greater benefit to adults and older adults with severe and persistent mental illness at a lower cost in California.

(d) Therefore, using the guidelines and principles developed under the demonstration projects implemented under the adult system of care legislation in 1989, it is the intent of the Legislature to accomplish the following:

(1) Encourage each county to implement a system of care as described in this legislation for the delivery of mental health services to seriously mentally disordered adults and older adults.

(2) To promote system of care accountability for performance outcomes which enable adults with severe mental illness to reduce symptoms which impair their ability to live independently, work, maintain community supports, care for their children, stay in good health, not abuse drugs or alcohol, and not commit crimes.

(3) Maintain funding for the existing pilot adult system of care programs that meet contractual goals as models and technical assistance resources for future expansion of system of care programs to other counties as funding becomes available.

(4) Provide funds for counties to establish outreach programs and to provide mental health services and related medications, substance

abuse services, supportive housing or other housing assistance, vocational rehabilitation, and other nonmedical programs necessary to stabilize homeless mentally ill persons or mentally ill persons at risk of being homeless, get them off the street, and into treatment and recovery, or to provide access to veterans' services that will also provide for treatment and recovery.

Section 5806. The State Department of Mental Health shall establish service standards that ensure that members of the target population are identified, and services provided to assist them to live independently, work, and reach their potential as productive citizens. The department shall provide annual oversight of grants issued pursuant to this part for compliance with these standards. These standards shall include, but are not limited to, all of the following:

(b) A client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and followthrough of services, and necessary advocacy to ensure that the client receives those services that are agreed to in the personal services plan. A client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, consult with the family and other significant persons as appropriate.

Section 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.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for 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.

W&I Section 5851

(1) To phase in the system of care for children with serious emotional and behavioral problems developed under this part to all counties within the state.

(2) To require that 100 percent of the new funds appropriated

under this part be dedicated to the targeted population as defined in Sections 5856 and 5856.2. To this end, it is the intent of the Legislature that families of eligible children be involved in county program planning and design and, in all cases, be involved in the development of individual child treatment plans.

(3) To expand interagency collaboration and shared responsibility for seriously emotionally and behaviorally disturbed children in order to do the following:

(A) Enable children to remain at home with their families whenever possible.

(B) Enable children placed in foster care for their protection to remain with a foster family in their community as long as separation from their natural family is determined necessary by the juvenile court.

(C) Enable special education pupils to attend public school and make academic progress.

(D) Enable juvenile offenders to decrease delinquent behavior.

W&I Section 5865.3. When a county system of care services children, zero to five years of age, the following structures and services shall be available, and when not available, the county plan shall identify a timeline for the development of these services:

(a) Collaborative agreements with public health systems, regional center services, child care programs, CalWORKs providers, drug and alcohol treatment programs, child welfare services, and other agencies that may identify children and families at risk of mental health problems that affect young children.

(b) Outreach protocols that can assist parents to identify child behaviors that may be addressed early to prevent mental or emotional disorders and assure normal child development.

(c) Identification of trained specialists that can assist the parents of very young children at risk for emotional, social, or developmental problems with treatment.

(d) Performance measures that ensure that services to families of very young children are individual, identified by the family, and developmentally appropriate.

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 Mental Health 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.

W&I Section 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.

Mental Health Services Act (Prop 63)

SECTION 3. Purpose and Intent.

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

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

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

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

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

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

CPAW AGENDA ITEM
READINESS WORKSHEET

CPAW Meeting Date:
- ✓ December 1, 2011

Name of Committee / Individual:
- ✓ N/A

1. **Agenda Item Name:**
   - ✓ CSS Program #2 Update – TAY FSP

2. **Desired Outcome:**
   - ✓ Information update and discussion

3. **Brief Summary:**
   - ✓ The purpose of this agenda item is to provide an update on CSS Program #2, Transition Age Youth (TAY) Full Service Partnership (FSP) program in accordance with the CPAW master calendar for all MHSA program updates. Please refer to the CSS Program Presentation Template for specific details about the TAY FSP Program.

4. **Specific Recommendation:**
   - ✓ None

5. **Background:**
   - ✓ See Brief Summary above.

6. **Funding Considerations[1]:**

If this item includes funding, please answer the following relevant questions-
- What funding category does this item fall under?
- In that category, how much money has already been spent? How much remains?
- How much would this proposal cost (with as much precision as can be offered)?
- What other proposals are pending in this category and what are their associated costs?
- What proportion of the funding category would this program represent?
- Is there any other important funding context needed (e.g. Reversion deadlines)?

CPAW Role: What is the desired and appropriate level of CPAW engagement?
- ✓ Receive

Choose from the following[2]:
- **Receive-** Increase understanding
- **Reality Check-** Tell us if we're hot, warm, cold
- **For Future Approval-** Information to prepare for a future decision
- **Advising-** Deliberate, weigh the pros and cons and get back to us
- **Approval-** Simple yes or no, go or no go

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[1] Please offer visual representations when possible.
[2] Please note that the levels of engagement are in ascending order- from lesser to greater levels -of engagement. The greater the level of engagement, the more background and context should be provided by the committee.

7. **Other Important Factors:**
   - Who else is influencing this item?
   - Is there an upcoming deadline?

8. **Anticipated Time Needed on Agenda:**
   - ✓ 30 minutes

9. **Who will report on this item?**
   - ✓ Holly Page

CPAW AGENDA ITEM
READINESS WORKSHEET

CPAW Meeting Date: December 1, 2011 **Name of Committee/** Suicide Prevention

1. **Agenda Item Name***):* PEI Program 4, Suicide Prevention

2. **Desired Outcome** *(as you'd like it to show on the CPAW Agenda):* Approval of a pilot program to reduce suicide among the clients we serve.

3. **Brief Summary:** The Suicide Prevention Committee has been meeting for over a year, considering models of suicide prevention and examining the data on those who have touched our system and died by suicide. While the committee has not yet finalized their recommendations, we see an opportunity to pilot a project Modeled after the suicide prevention protocol developed by the Henry Ford Health System in Detroit, Michigan. The components include, training staff in CBT for Depression, a concerted effort to support means reduction, Follow-up phone calls for persons at risk of suicide, and drop in support groups for those who are at risk. We would like to pilot this project in Central County where the highest rate of suicide occurs.

4. **Specific Recommendation** *(if applicable):* Update the PEI Plan to include the pilot program and allocate funds to hire a Mental Health Clinical Specialist to do drop in groups for those at risk of suicide and fund staff for follow up phone calls.

5. **Background:** What context is needed for CPAW members to understand this item? What's the history that CPAW members need to be aware of for discussion or approval? (eg. Is this building on a previous committee recommendation?) What else should CPAW members know about the rationale that guided the committee or individual to this point? Please see above.

6. **CPAW Role:** What is the desired and appropriate level of CPAW engagement? Support for implementation of this pilot program.

Choose from the following[1]:

- **Receive-** Increase understanding
- **Reality Check**- Tell us if we're hot, warm, cold
- **For Future Approval**- Information to prepare for a future decision
- **Advising**- Deliberate, weigh the pros and cons and get back to us
- **Support- Simple yes or no, go or no go**

7. **Other Important Factors:**

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[1] Please note that the levels of engagement are in ascending order- from lesser to greater levels -of engagement. The greater the level of engagement, the more background and context should be provided by the committee.

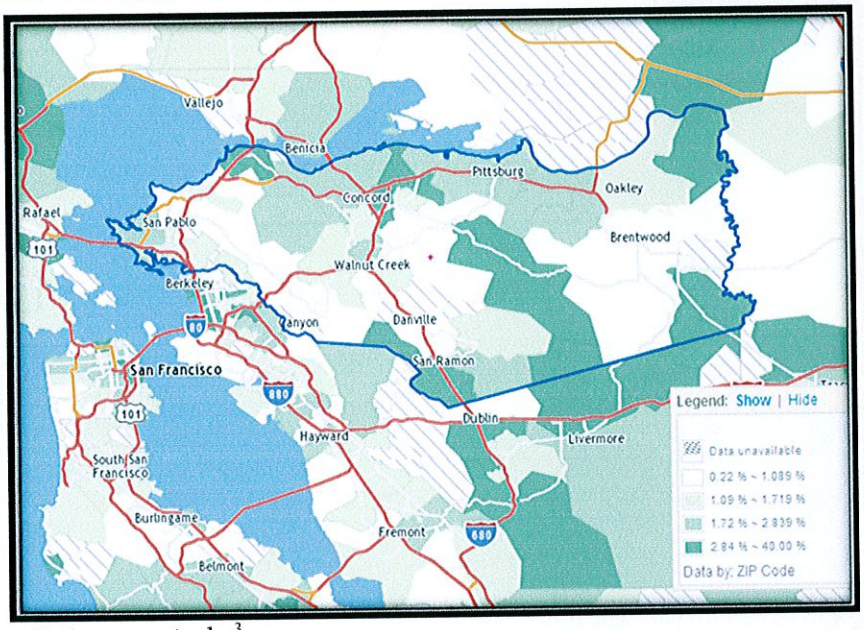
Who else is influencing this item? The Henry Ford Workgroup of the Suicide Prevention Committee.
Is there an upcoming deadline? We would like to train staff soon and create project position to do the drop-in groups and either contract for or providing staffing for the follow up phone calls. This would be MHSA PEI funds in the amount of $145,000.00. I would recommend using unspent PEI funds.

8. **Anticipated Time Needed on Agenda:** 20 minutes
9. **Who will report on this item?** Mary and Holly

Suicide Prevention Initiative
Prevention and Early Intervention Statewide Project
Contra Costa County

Contra Costa County is the ninth most populous county in California, with its population reaching approximately 1,051,677 in January 2008.[1] Over 50 percent of the population is Caucasian, approximately 23 percent are Hispanic and 13 percent are Asian.[2] The median age is 38 years. The population is fairly distributed across all age ranges with an average of 27 percent of the population in each of the following age categories: under 18 years; 25 to 44 years; and 45 to 64 years.[1] Nine percent of the population is between 18 and 24 years old and 12 percent are 65 years or older.[1] Lastly, approximately 9.4 percent of Contra Costa County residents live in poverty[3]; yet, the median household income is close to $80,000.[4]

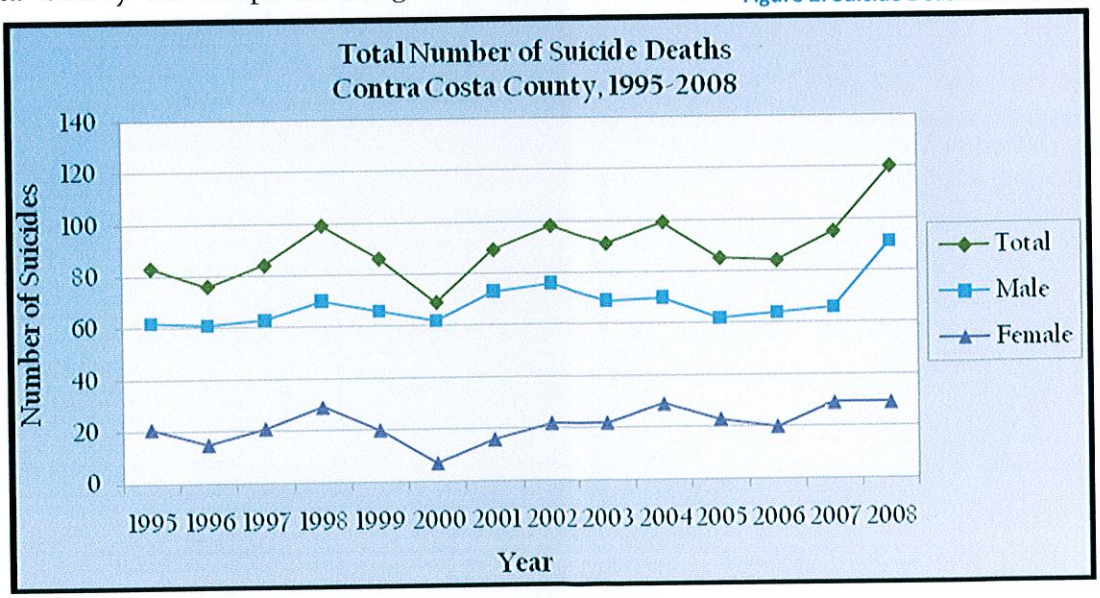
Figure 1: Percent of Suicides by Zip Code



Contra Costa County is generally segregated into three distinct areas: West, Central and East County. Each region is geographically and demographically diverse. In 2009, in the Central region, White (64%) and Latino (20%) make up the majority. The East region of the county is largely comprised of White (39%) and Latino (33%). In contrast, the West region of the county is predominately White (26%), Latino (24%), and African-American (24%).[1] Figure 1 shows Contra Costa County separated by zip code to detail the percent of suicides that occur in each area.[5] The suicide death rates within Contra Costa County are highest among residents of Walnut Creek and Concord in the Central region; as well as Antioch in the East region, with suicide death rates of 13.6, 11.7 and 10.6, respectively.[3]

In 2008, there were 120 reported suicide deaths in Contra Costa County[6]; that represents a 26 percent increase from the previous year and a 43 percent increase from 2006. (Figure 2) Overall, males account for a far greater proportion of all suicide deaths when compared to females in Contra Costa County. In line with California statistics, the highest numbers of suicides in Contra Costa County are completed using firearms, followed by hanging/suffocation, and drug overdose/poisoning.[6] In 2007, the overall suicide death rate for Contra Costa County was 9.3 per 100,000 population which is slightly lower than the California suicide death rate in 2007 of 9.4 per 100,000 population.[7] Contra Costa County is not meeting the Healthy People 2010 goal of 5 suicides per 100,000 population.[8]

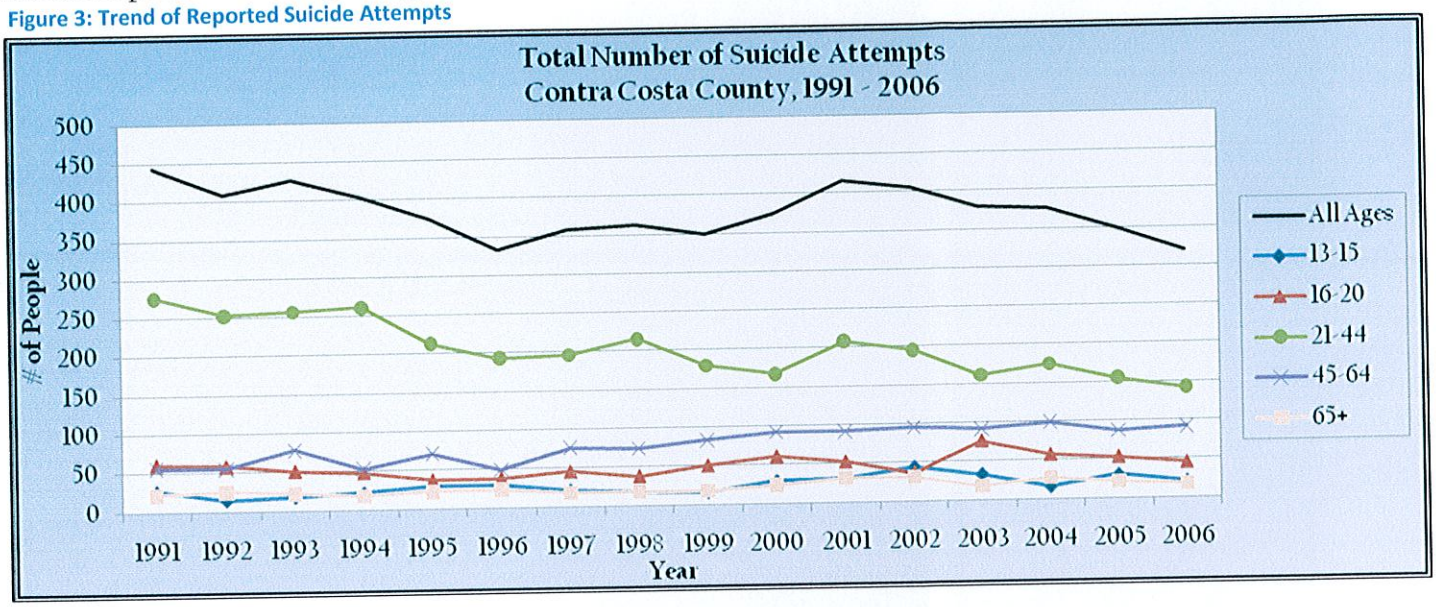
Figure 2: Suicide Death Trend 95-08



Since 2001, there has been a decrease the in number of reported suicide attempts.[9] (Figure 3) In 2006, there were a total of 320 attempts suicides reported in Contra Costa County.[9] Suicide attempts are thought to be drastically underreported for several reasons. First, not all suicide attempts result in a hospitalization and thus may never be reported and recorded as a suicide attempt. The Center for Disease

Control and Prevention reports among young adults' ages 15 to 24 years, there are approximately 100 to 200 attempts for every completed suicide.[10] For all ages, it is approximated that there is one suicide for every 25 attempted suicides.[10] If this statistic is applied to Contra Costa County, it can be inferred that 2,100 people attempted suicide in 2006 (given the number of suicides deaths in 2006 was 84). This means as many as 1,780 suicide attempts went unrecognized. Many organizations have acknowledged the underreporting of suicide attempts and thus have recommended and advocated for increase sophistication of reporting methods.[10,11]

Figure 3: Trend of Reported Suicide Attempts



Of the reported suicide attempts in Contra Costa County, approximately 65 percent of non-fatal attempts were among White people, 14 percent were among African-American and 10 percent Hispanic.[9] Although the African-American population accounts for the second highest number of non-fatal attempts, this same population accounts for the lowest percentage of suicide deaths in Contra Costa County (5%) when compared to White, Asian and Hispanic races. In Contra Costa County, more men die by suicide, however more women attempt suicide; 63 percent of all attempts in 2006 were women in Contra Costa County.[7] This statistic transcends the boundaries of this county and is true for the entire nation. Of those who attempted suicide in Contra Costa County, 82 percent were a result of poisoning followed by cutting/piercing at 10 percent.[9]

Protective Factors and Risk Factors of Suicide

Suicide is an important and preventable public health problem. The World Health Organization has estimated that 815,000 people worldwide died by suicide in year 2000, far outnumbering the reported 520,000 homicide deaths.[12] The cause of suicide is an extremely complex issue in which multiple interacting risk and protective factors come into play. A risk factor, in this context, may be thought of as leading to or being associated with suicide; that is, people who experience the risk factors for suicide are at greater potential for suicidal behavior. However, it is important to note, many people may have these risk factors, but are not suicidal. Figure 4 describes risk factors identified in relation to suicide.

Figure 4: Risk Factors[13,14]

Biopsychosocial Risk Factors	Environmental Risk Factors	Sociocultural Risk Factors
• Mental Disorders • Hopelessness • Impulsive and/or aggressive tendencies • History of trauma or abuse • Alcohol and other substance use disorder • Previous suicide attempt • Family history of suicide	• Job or Financial Loss • Relational or Social Loss • Easy Access to Lethal Means • Local clusters of suicide that have a contagious influence	• Lack of Social Support and sense of isolation • Stigma associated with help-seeking behavior • Barriers to accessing health care, especially mental health and substance abuse treatment • Certain cultural and religious beliefs • Exposure to, including through the media, and influence of others who may have died by suicide

There are several protective factors related to suicide. (Figure 5) Protective factors reduce the likelihood of suicide. They can enhance resilience and may serve to counterbalance risk factors.[13, 14] Protective factors are quite varied and include an individuals' attitudinal and behavioral characteristics, as well as attributes of the environment and culture.[14,15]

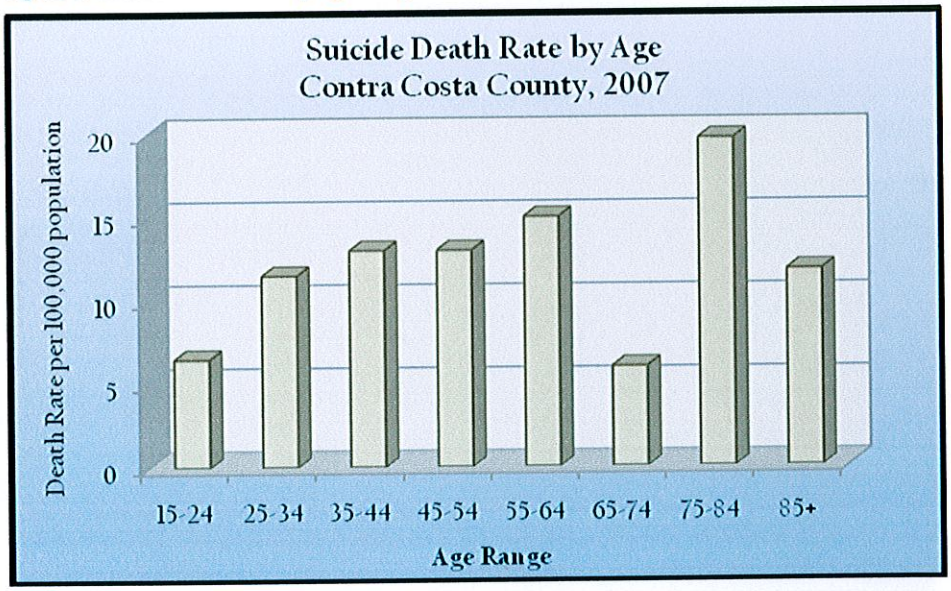
Figure 5: Protective Factors

Protective Factors
• Effective clinical care for mental, physical and substance use disorders
• Easy access to a variety of clinical interventions and support for help-seeking
• Restricted access to highly lethal means of suicide
• Strong connections to family and community support
• Support through ongoing medical care and mental health care relationships
• Skills in problem solving, conflict resolution, and nonviolent handling of disputes
• Cultural and religious beliefs that discourage suicide and support self-preservations

Influence of Age on Suicide

Among Contra Costa County residents 15 to 34 years old, suicide is the third leading cause of death, after unintentional injuries and homicide.[3] Studies show a dramatic decrease in the youth suicide rate during the past decade. Research on this trend attributes the decrease in youth suicide rate to the increase in antidepressants being prescribed to adolescents during this same time period.[4] Within Contra Costa County this same trend proved to be true with an all time low number of youth suicide in 2003. There were only three reported suicides for residents under the age of 25.[6] Unfortunately, the trend reversed over the last several years in Contra Costa County. The number of suicides within the same population has steadily increased since 2003 with 12 suicides being reported in 2007.[6]

Figure 6: Suicide Death Rate by Age Range in Contra Costa County

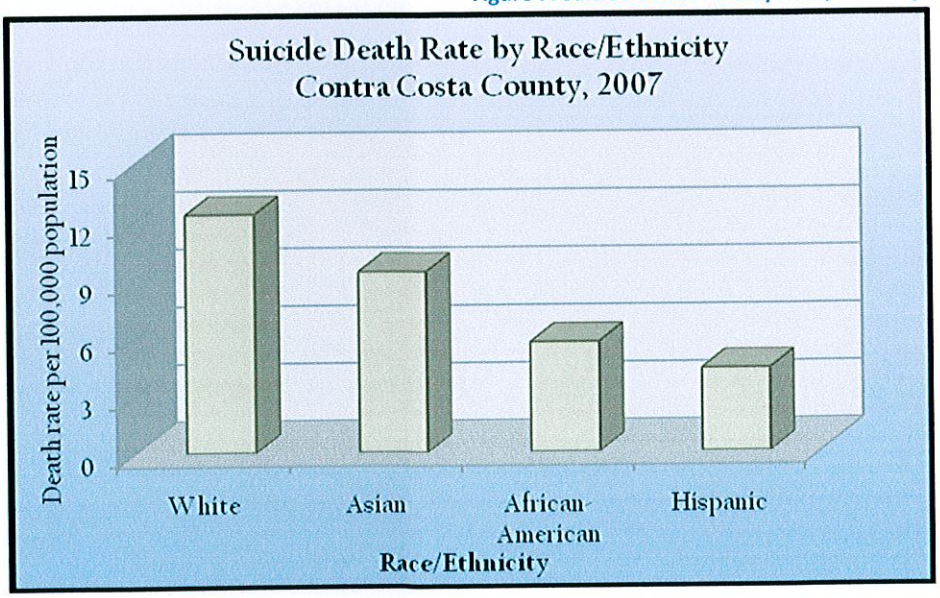


For those residents between the ages of 45 and 64 years old, suicide remains a leading cause of death with a death rate of approximately 14 per 100,000 people.[7] (Figure 6) This rate well exceeds the State's rate of 9.4 and the County's overall rate of 9.3 suicides per 100,000 people.[6] Yet, suicide is not in the top five leading causes of death for Contra Costa County residents over the age of 55 as the prevalence of chronic diseases increases with age.[3] However, when considering the number of deaths by suicide within each age range, it is apparent the older adult population is a high-risk group even though they are more likely to die from a chronic disease than from suicide.

Influence of Race/Ethnicity on Suicide

In 2007, the majority of suicide deaths in Contra Costa County occurred among Caucasian residents with a suicide death rate of 12.4 per 100,000 followed by Asians, African-Americans and Hispanics with suicide death rates of 9.5, 5.7, and 4.3, respectively.[7] (Figure 6) When the suicide death rates are converted to percentages, approximately 72 percent of all suicides are among Caucasians; 12 percent among Asian; 10 perecnt are Hispanic and just over 5 percent are African-American.[7] Although Hispanics account for more suicide deaths than African-Americans, the rate of suicide deaths is higher for African-

Figure 7: Suicide Death Rate by Race/Ethnicity

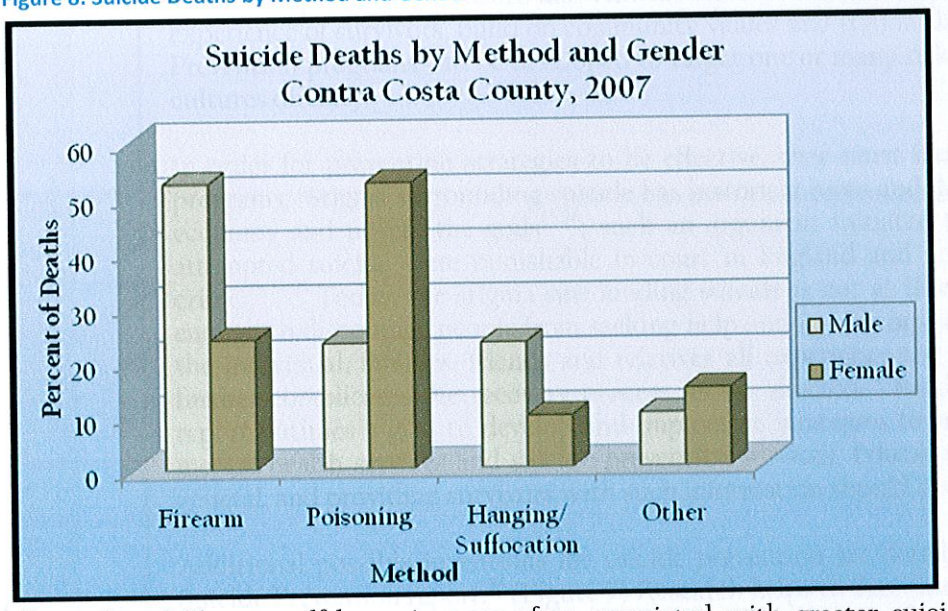


American then for Hispanics. The calculation of the suicide death rate takes into account the size of the population of focus; in this case, either the total number of Hispanics or African-American residents in Contra Costa County. This simply means that although fewer African-Americans died by suicide their risk of suicide is greater when compared to the Hispanic population.

Influence of Gender on Suicide

In 2007, 76 percent of people who died by suicide in Contra Costa County were male.[6] Although more men die from suicide, more women attempt suicide. In 2006, approximately 63 percent of attempted suicides in Contra Costa County were female.[13] Males and females tend to utilize different means for suicide. In most cases, males engage in far more lethal means during the attempt thus resulting in more male deaths when compared to females. (Figure 8) The method used during the suicide attempt is a predictor of the outcome of the action. In Contra Costa County, women are almost twice as likely to attempt suicide by poisoning; whereas, firearms and hanging are the predominate methods used among males.[6,13]

Figure 8: Suicide Deaths by Method and Gender



One study suggests acts of deliberate self-harm by females are more often based on non-suicidal motivation, but for males, deliberate self-harm is more often associated with greater suicidal intent.[15] More research is needed to determine the extent to which social, genetic and biological factors, in association with gender, contribute to the risk of suicide.

Suicide and LGBTQ Youth

As previously mentioned, suicide is the third leading cause of death for people ages 15 to 24 years[16]; however, more youth survive suicide attempts then actually die.[17] The overall rate of suicide among youth, ages 15 to 24 years, in California is 6.9 per 100,000.[18] While Contra Costa County's rate is the same as for the state as a whole, 6.9 per 100,000, the rate is higher than its neighbor, Alameda County's, rate of 6.4 per 100,000.[18] The Suicide Prevention Resource Center reviewed studies and reports about youth suicide and concluded LGBTQQI2-S (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Two-spirit) youth are a high-risk group for suicide.[18] Their research indicates LGBTQQI2-S youth are two to four times as likely to attempt suicide as compared to heterosexual youth.[18] Therefore, it can be inferred that the expected rate of suicide for LGBTQQI2-S youth in Contra Costa County is 14 to 28 per 100,000 people.

Moreover, recent research conducted in California, concluded the degree to which a family rejects or accepts their LGBTQQI2-S youth because of his or her sexual orientation during his or her adolescence has a correlation with the adolescent's health outcomes.[19] Adolescents who experienced high rejection were 8.4 times more likely to attempt suicide.[19] The increase in suicide and suicide attempts for this specific population of youth can be attributed to an increase the sociocultural risk factors that are present in the youth's lives. The social and internalized stigma that is intertwined with sexual identification of the youth can lead to isolation and rejection. Services available are inadequate to meet the needs of this population and the lack of a social support network further compounds the issue.[18,19]

Influence of Economic Environment on Suicide

The current economic crisis being experienced worldwide, and especially in the United States, begs the question of whether or not the economic environment influences the rate of suicide. The health effects of economic insecurity are uncertain. Research conducted during the last U.S. economic depression was inconclusive. A study conducted in 1991, concluded that evidence for effects on suicide is characterized as weak or sufficiently controversial to warrant skepticism.[20] Moreover, two studies conducted in 1978 and 1982 revealed small associations between economic stress and suicide or suicidal ideation.[21] Contradictory, an analysis conducted in 2009 reported suicide is cyclical, meaning rates go up during an economic downturn; mental health also suffers during such periods.[22] Lastly, a study published in 1995 stated people who died by suicide were more likely to be jobless when they died than were people who died from other

Indicated The intervention is designed for specific individuals who, on examination, have a risk factor or condition that puts them at very high risk.	Implement cognitive-behavioral therapy immediately after patients have been evaluated in an emergency department following a suicide attempt	Teach caregivers to remove firearms and old medicines from the home before hospitalized suicidal patients are discharged	Develop and promote honorable pathways for law enforcement officers to receive treatment for mental and substance use disorders and return to full duty without prejudice

Incorporating the Statewide Strategic Plan

California Department of Mental Health released the *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution* in June of 2008.[32] Several strategies for suicide prevention are detailed in the report with further detail for recommended actions at the State and local levels. The report refers to the following as "Strategic Directions": creating a system of suicide prevention; implementing training and workforce enhancements; educating communities to take action; and improving program effectiveness and system accountability. Additionally, six core principles were defined to guide all levels of planning, service delivery and evaluation. The core principles are described below:

Core Principle	Description	Key points
One	Implement culturally competent strategies and programs that reduce disparities.	• Goal is to reduce disparities in the availability, accessibility and quality of services for racial, ethnic and cultural groups • Planning processes should involve members of the target population of focus
Two	Eliminate barriers and increase outreach and access to services.	• Information, programs and materials: o Need to be accessible and available in a variety of languages and formats o Should ensure that all people of diverse backgrounds and abilities, including physical, psychiatric and age-related disabilities, have access to equitable services
Three	Meaningfully involve survivors of suicide attempts; the family members, friends, and caregivers of those who have completed or attempted suicide; and representatives of target populations.	• Include those who have survived a suicide attempt and their family members, friends and caregivers as they bring important personal experiences and unique perspectives to identify service needs and gaps in the system • Peer Support and education are invaluable components of a comprehensive system for suicide prevention
Four	Use evidence-based models and promising practices to strengthen program effectiveness.	• Attention should be given to replicating and disseminating or adapting effective program models and promising practices. • Program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs
Five	Broaden the spectrum of partners involved in a comprehensive system of suicide prevention	• Develop long-term partnerships with a broad range of partners that transcend the traditional mental health system • Examples of partnership include: business community; senior centers; spiritual and faith communities; private foundations; Veterans Affairs, etc.
Six	Employ a life span approach to suicide prevention.	• Suicide prevention and intervention activities should be targeted to people of all ages from children and youth, to adults, and older adults.

As previously mentioned, these six core principles are further organized by two levels of focus for suicide prevention: strategic directions and recommended actions. When considered together, the core principles, strategic directions and recommended actions are intended to lay the foundation for a comprehensive system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems and identifies and fills gaps in services and programs.

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Contra Costa County Suicide Prevention Committee

Suicide Prevention Workgroup: Henry Ford Health System Model

Workgroup Members:

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Over the last three years, 2008-2010, an average of 116 people each year died by suicide in Contra Costa County. The profile of those who die by suicide and the means used to complete suicide in this county resembles that of the nation.

Within Contra Costa County, approximately 30 percent of those who kill themselves each year have received at least one service at any of the following locations: County Mental Health Clinics, Network Providers, Contra Costa Regional Medical Center Inpatient Unit or at the Crisis Stabilization Unit (PES).

The Contra Costa County Suicide Prevention Committee is charged with drafting a county-wide strategic plan aimed at reducing attempted and completed suicides. The Perfect Depression Care model, implemented at Henry Ford Health System in Detroit, caught the attention of the Committee as it successfully reduced the number of suicides to zero from 89 per 100,000 for nine consecutive quarters. The Committee established a workgroup to further research the components of the model and determine the potential adaptability in Contra Costa County.

After several phone conversations with the Vice President of the Henry Ford Health System and the CEO of Behavioral Health Services, the Workgroup began a chart review of those who died by suicide in Contra Costa County and had received services within at least one of the locations mentioned previously. The chart review allowed the workgroup to retrospectively analyze the services, care and follow-up provided to individuals prior to their suicide and to determine if any of the model components could have influenced the trajectory of the individual. The mindful scrutinization of the documentation was eye-opening and compelling.

The review shed light on how a more comprehensive approach to addressing suicidality may result in better outcomes. The infrastructure in which services are provided lacks suicide-specific prevention components. The current system provides a binary approach to suicide assessment – an individual is suicidal or is not – and a binary approach to treatment – if suicidal, an individual is hospitalized and if not hospitalized, referred for routine outpatient care. The workgroup considered the intervention available to people in the Henry Ford Health System and came to a consensus that similar services in Contra Costa County would dramatically impact the incidence of suicide.

The proposed model would attempt to eliminate the binary approach to suicidal intent and risk by developing a safety net for individuals at all risk levels. Coordination of existing services and the development of additional resources would result in a more comprehensive nuanced system in which the primary goal is to address suicide and decrease the incidence within the county. The following components are proposed at crucial elements to suicide prevention in this county:

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- Outreach to individuals identified by providers or community members
- Ongoing education and awareness
- Suicide drop-in groups at multiple locations in each region
- Physicians extenders for follow-up calls and visits
- Website specific to suicide prevention, resources and efforts of the program
- Intentional focus on means reduction and family/support system involvement
- Develop partnerships with other local inpatient and outpatient service providers
- Potential partners could include:
  - Peer-support providers
  - Psychiatrists
  - Substance abuse specialists
  - Financial Counselors
  - Contra Costa Crisis Center
  - Access Line
  - Clinicians trained in CBT

Forming a collaboration with other community partners would allow for the flexibility required to provide services to all individuals, publicly-insured, privately insured and uninsured, in need in Contra Costa County. The success of the Henry Ford Health System involved significant transformation of the health care provision culture which led not only to reduction in the suicide rate, but to cost reduction over time as well. The long term financial impact would be nominal and the cost would be partially, if not entirely offset, by the reduction in hospitalizations, emergency visits and lost life years.

Possible funding sources for this program include MHSA Innovation, MHSA Prevention and Early Intervention, MHSA Workforce Education and Training, MediCal and MediCare reimbursement, Private Insurance contributions and/or reimbursements and other appropriate sources.

The Henry Ford Workgroup would appreciate your consideration of this proposal.

Attachments:
Henry Ford Health System Suicide Prevention Model Summary
Contra Costa County Suicide Statistics