Board of Directors Meeting

AGENDA

June 13, 2013

Open Meeting
2:45 p.m. – 4:30 p.m.

Closed Session
4:30 p.m. – 5:00 p.m.

Call-In Information: 1-877-339-2412
Conference Code: 2250381321
(listen in only)

Meeting Location:

Doubletree Hotel Sacramento
2001 Point West Way
Sacramento, CA 95815
(916) 929-8855

California Mental Health Service Authority (CalMHSA)

Board of Directors Meeting Agenda

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In compliance with the Americans with Disabilities Act, if you are a disabled person and you need a disability-related modification or accommodation to participate in this meeting, please contact Laura Li at (916) 859-4818 (telephone) or (916) 859-4805 (facsimile). Requests must be made as early as possible, and at least one full business day before the start of the meeting.

Materials relating to an item on this agenda submitted to this Board after distribution of the agenda packet are available for public inspection at 3043 Gold Canal Drive, Suite 200, Rancho Cordova, CA, 95670, during normal business hours.

A. BOARD OF DIRECTORS MEETING **2:45 p.m. – 4:30 p.m.**

1. **CALL TO ORDER**
2. **ROLL CALL AND INTRODUCTIONS**
3. **INSTRUCTIONS FOR PUBLIC COMMENT AND STAKEHOLDER INPUT -** The Board welcomes and encourages public participation in its meetings. This time is reserved for members of the public (including stakeholders) to address the Board concerning matters on the agenda. Items not on the agenda are reserved for the end of the meeting. Comments will be limited to three minutes per person and 20 minutes total.

   For agenda items, public comment will be invited at the time those items are addressed. Each interested party is to complete the Public Comment Card and provide it to CalMHSA staff prior to start of item. When it appears there are several members of the public wishing to address the Board on a specific item, at the outset of the item, the Board President may announce the

maximum amount of time that will be allowed for presentation of testimony on that item. Comment cards will be retained as a matter of public record.

4. CMHDA STANDING REPORT

A. CMHDA Standing Report 7

Recommendation: None, information only.

5. STATEWIDE PEI PROGRAMS

A. Program Partner Presentation – University of California Office of the President – Student Mental Health Initiative: University of California Student Mental Health Program (UCSMHP) 8

Recommendation: None, information only.

6. APPROVAL OF AGENDA AS POSTED (OR AMENDED)

7. CONSENT CALENDAR - If the **Board** would like to discuss any item listed, it may be pulled from the Consent Calendar. 11

A. Routine Matters:

a. Minutes from the April 12, 2013 Board of Directors Meeting 42

B. Reports/Correspondence:

a. CalMHSA Goal Statements Grid 54

b. Treasurer's Report as of December 31, 2013 57

c. Treasurer's Report as of March 31, 2013 61

d. Unaudited Financial Statements for the Quarters Ended December 31, 2013 and March 31, 2013 65

e. Sample Contract Specialist Professional Service Agreement 2013–14 75

f. RAND Contract Amendment for TTACB 79

Recommendation: Staff recommends approval of the Consent Calendar.

8. MEMBERSHIP

A. CalMHSA New County Membership Application(s) 12

Recommendation: Approve CalMHSA membership for Alameda County.

B. County Outreach Report – Allan Rawland, Associate Administrator–Government Relations 13

Recommendation: None, information only.

9. FINANCIAL MATTERS

A. Report from the CalMHSA Finance Committee – Scott Gruendl 14
Recommendation: None, information only.

B. CalMHSA Annual Revenue and Expenditure Report – Proposed Budget June 30, 2014 15
Recommendation: Adopt the Annual Revenue and Expenditure Report – Proposed Budget, June 30, 2014.

10. PROGRAM MATTERS

A. Report from CalMHSA Program Director – Ann Collentine 16
Recommendation: None, information only.

B. Report from CalMHSA Advisory Committee – Maureen Bauman 17
Recommendation: None, information only.

C. SDR Consortium Administration 18
Recommendation: None, information only.

D. Plan Update Contract Amendments 22
Recommendation: Authorize staff to negotiate amended contracts for Program Partners, as recommended by the Advisory Committee, and authorize the Executive Director and President to execute such amendments on behalf of CalMHSA.

E. Enhancing Efforts to Reduce Disparities – Supporting Cultural Responsiveness 27
Recommendations:

1. **Approval to extend contract with CiMH for up to $100,000 to coordinate and deliver expedited training and technical assistance based on findings from the assessment to enhance efforts to reduce disparities.**
2. **Approve contracting with the California Reducing Disparities Project (CRDP) to develop tool kits for Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health by December 31, 2013 for a total of no more than $150,000.**

F. State Hospital Beds 30
Recommendation: Approval to continue negotiations for a joint contract and operationalize the DSH Beds with CalMHSA for FY 2013-14.

11. ADMINISTRATIVE MATTERS

A. Executive Committee Election 33

Recommendation: Approve recommended slate of officers and Executive Committee members representing the five CMHDA regions.

B. Strategic Planning Session Follow-up 34

Recommendation: Approval for staff to analyze and report back on the recommended projects listed above.

12. GENERAL DISCUSSION

A. Report from CalMHSA President – Wayne Clark 37

- PEI Statewide Project Sustainability Task Force Appointments
- General

Recommendation: Discussion and/or action as deemed appropriate.

B. Report from CalMHSA Executive Director – John Chaquica 38

- Department of Health Care Services Contract
- Media Postings at www.calmhsa.org
- General

Recommendation: Discussion and/or action as deemed appropriate.

13. PUBLIC COMMENTS

A. **Public Comments Non-Agenda Items**

This time is reserved for members of the public to address the Board relative to matters of CalMHSA not on the agenda. No action may be taken on non-agenda items unless authorized by law. Comments will be limited to three minutes per person and 20 minutes in total. The Board may also limit public comment time regarding agenda items, if necessary, due to a lengthy agenda.

14. NEW BUSINESS - General discussion regarding any new business topics for future meetings.

15. CLOSING COMMENTS - This time is reserved for comments by Board members and staff to identify matters for future Board business.

A. Board
B. Staff

16. ADJOURNMENT

B. CLOSED SESSION **4:30 p.m. – 5:00 p.m.**

The CalMHSA Board of Directors will meet in closed session as permitted by Government Code Section 54957(b).

1. **CALL TO ORDER**
2. **ROLL CALL**
3. **PROGRAM MATTERS**
   A. Performance evaluation of the Executive Director pursuant to Government Code Section 54957(b).
   Recommendation: None, information only. (No action required. If action is taken, the board will report out at the beginning of the following board of director's meeting.)
4. **CLOSING COMMENTS**
5. **ADJOURNMENT**

CMHDA STANDING REPORT
Agenda Item 4

SUBJECT: CMHDA Standing Report

BACKGROUND AND STATUS:

In discussions amongst CalMHSA and CMHDA staff, and later proposed to CalMHSA officers, there will be a standing agenda item for CMHDA staff to present items that are relevant to be discussed at CalMHSA Board meetings. To the extent there are such items, CMHDA will address CalMHSA at each Board meeting. Such discussions, unless otherwise known, are intended to be informational only and not subject to action.

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- None

STATEWIDE PEI PROGRAMS

Agenda Item 5

SUBJECT: Program Partner Presentation – University of California Office of the President – Student Mental Health Initiative: University of California Student Mental Health Program (UCSMHP)

BACKGROUND AND STATUS:

In 2011, in response to the increased severity and demand for services, collaboration between the 10 UC campus Student Affairs offices and the UC Office of the President (UCOP) Student Affairs resulted in a proposal and subsequent award of a $6.9 million student mental health grant funded by the California Mental Health Services Authority (CalMHSA) through Proposition 63.

Each campus received $500,000, with the remaining set aside for system-wide programming and contract management. The goal was to enhance existing mental health services and create new prevention and early intervention programming.

In November 2012, CalMHSA dissolved their contingency reserve fund and opened a call for proposals to supplement current contracts. UCOP applied and, as of January 2013, was awarded an additional $877,224. Of this additional funding, $127,224 was retained by UCOP for system-level programming and the remaining $750,000 was distributed to the campuses.

Summary of Programmatic Deliverables

1. Training for students, faculty/staff, and graduate teaching/research assistants on how to recognize and respond to students in distress.
2. Development of a comprehensive, system-wide approach to suicide prevention.
3. Creation of Social Marketing/Awareness campaigns to reduce stigma and discrimination for those living with a mental illness.
4. Production of system-wide public service announcements (PSA's) and training videos to support the social media campaign.
5. Development of an online resource clearinghouse (Website) to facilitate collaboration with other mental health stakeholders across California.
6. Increased collaboration with local County Mental Health departments and systems of higher education (CCC & CSU).
7. Planning and implementation of a culminating Best Practice conference in 2014 to showcase mental health advancements across the UC, CSU & CCC systems.

Progress and highlights to date:

- Each campus was able to hire at least one additional psychologist to manage new programming and assist with clinical services.
- Faculty/Staff Training - Each campus has enhanced their training materials and increased the number of trainings provided to faculty and staff.
    - Nine out of 10 campuses have completed the Red Folder. They continue to distribute the folders during faculty/staff training and deliver copies by request to various departments.
    - Collectively (January–March 2013), the CAPS staff conducted 91 faculty and staff trainings with over 2,100 faculty and staff members attending the various training on recognizing and responding to students in distress.
- Student Training - 400+ additional mental health training/outreach opportunities for students (i.e., bystander, peer leader, suicide prevention).
    - Collectively (January–March 2013), the UC campuses conducted a total of 347 student training with over 8,328 students attending a variety of training including a weekend retreat focused on social justice and multiculturalism, a Mental Health Wellness and Coping presentation.
- Online Interactive Depression and Suicide Screening program (ISP) – nine of 10 campuses have launched the ISP.
    - This quarter, the CAPS staff invited 11,796 students to take the ISP assessment.
    - Since the beginning of the contract, all campuses have screened at least 5% of students.
- Increased collaboration between the three public higher education systems (UC, CSU, CCC) and County Mental Health have led to collaborative workgroups (i.e., Riverside, Merced, Santa Barbara, Irvine, San Diego).
- On March 8, 2013, the UC system-wide Mental Health Summit was held at UC Irvine. The Summit was attended by approximately 100 invited representatives from the UC Office of the President, ten UC campuses, the CSU and CCC systems, CalMHSA, and Orange, Riverside, and Los Angeles County Departments of Mental Health. The Summit provided the opportunity for participants to share mental health-related emerging issues and concerns, and promising practices on their campuses or in their organizations.
- UCOP hosted a series of two training to educate the community on Social Media Ethics. Approximately 90 mental health professionals from the UC, California State University, and California Community College systems were trained on this topic.

- Social Marketing & Electronic Resources
    - Will launch system-level Facebook and Twitter page.
    - Developing a series of PSA's and training videos to be leveraged by partners (preview).
    - Will launch SMHP Website (preview).
- Psychologists continue to present SMHI research at professional conferences and publish articles.
    - American Psychological Association (APA)
    - National Association for Higher Education Administrators (NASPA)
    - International Multicultural Summit of Psychologists
    - Counseling Psychologist article (see attached)

Immediate next steps:

- Complete development and launch SMHP Website.
- Systematize method for delivering campus updates to County Mental Health Departments using campus fact sheets.
- Develop a committee for the Best Practice conference.

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- Effective Suicide Prevention in Higher Education (The California Psychologist)

CONSENT CALENDAR
Agenda Item 7

SUBJECT: Consent Calendar

BACKGROUND AND STATUS:

The Consent Calendar consists of items that require approval or acceptance but are self-explanatory and require no discussion. If the Board would like to discuss any item listed, it may be pulled from the Consent Calendar.

A. Routine Matters

1. Minutes from the April 12, 2013 Board of Directors Meeting

B. Reports/Correspondence

2. CalMHSA Goal Statements Grid
3. Treasurer's Report as of December 31, 2013
4. Treasurer's Report as of March 31, 2013
5. Unaudited Financial Statements for the Quarters Ended December 31, 2013 and March 31, 2013
6. Sample Contract Specialist Professional Service Agreement 2013–14
   Six professional services contracts for a Contract Specialists, one for each CMHDA Region (except the Southern Region which selected to have two specialists with one serving the north and one serving the south region) have been executed per Board authorization taken in June 2012 and November 2012. Each contract is limited to under $100,000 per year and in total will not exceed Board authorization of $450,000. In keeping with Board procurement policy, the Board President and Treasurer have approved the execution of the individual contracts.
7. RAND Contract Amendment for TTACB

RECOMMENDATION:

Staff recommends approval of the Consent Calendar.

REFERENCE MATERIAL(S) ATTACHED:

- Minutes from the April 12, 2013 Board of Directors Meeting
- CalMHSA Goal Statements Grid
- Treasurer's Report as of December 31, 2013
- Treasurer's Report as of March 31, 2013
- Unaudited Financial Statements for the Quarters Ended December 31, 2013 and March 31, 2013
- Sample Contract Specialist Professional Service Agreement 2013–14
- RAND Contract Amendment for TTACB

MEMBERSHIP
Agenda Item 8.A

SUBJECT: CalMHSA New Membership Application(s)

BACKGROUND AND STATUS:

Alameda County has received membership approval from their Board of Supervisors, submitted their membership application to CalMHSA staff and now request approval as JPA members.

- The Alameda County board representative will be Alameda County Behavioral Health Care Services Interim Director Aaron Chapman, MD. The designated Alameda County board alternate will be Alameda County Behavioral Health Care Services Deputy Director Toni Tullys.

RECOMMENDATION:

Approve CalMHSA membership for Alameda County.

REFERENCE MATERIAL(S) ATTACHED:

- Alameda County Documentation

MEMBERSHIP
Agenda Item 8.B

SUBJECT: County Outreach Report – Allan Rawland, Associate Administrator – Government Relations

BACKGROUND AND STATUS:

During each Board of Directors meeting, Allan Rawland, Associate Administrator–Government Relations, will update the Board on the status of prospective new members. Staff has developed a spreadsheet to track activity of prospective members, which is attached as reference material.

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- CalMHSA Membership Roster
- County Outreach By Region

FINANCIAL MATTERS
Agenda Item 9.B

SUBJECT: CalMHSA Annual Revenue and Expenditure Report – Proposed Budget June 30, 2014

BACKGROUND AND STATUS:

The CalMHSA Bylaws provide for a fiscal year of July 1 to June 30, and require the Board of Directors to adopt the annual budget by July 1st of the new fiscal year. The draft budget is to be presented to the Board at least 45 days prior to the end of the fiscal year (Bylaws, §§ 4.1.3, 8.1, and 9.1.).

The Finance Committee reviewed and discussed a preliminary budget for year ended June 30, 2014. This budget has been developed according to the budget submitted in the implementation work plan and the first amendment to the implementation work plan. This preliminary draft budget was distributed by email on May 17, 2013 to the CalMHSA Board of Directors as the bylaws dictate.

RECOMMENDATION:

Adopt the Annual Revenue and Expenditure Report – Proposed Budget, June 30, 2014.

REFERENCE MATERIAL(S) ATTACHED:

- Annual Revenue and Expenditure Report – Proposed Budget, June 30, 2014

FINANCIAL MATTERS
Agenda Item 9.A

SUBJECT: Report from CalMHSA Finance Committee – Scott Gruendl

BACKGROUND AND STATUS:

The Finance Committee (FC) members are:

Chair	Mr. Scott Gruendl, CalMHSA Treasurer, Glenn County
Bay Area	*TBD*
Central	Mr. Tom Sherry, Sutter-Yuba Counties
Los Angeles	Dr. William Arroyo, Los Angeles County
Superior	Ms. Amy Wilner, Butte County
Southern	Ms. Tanya Bratton, San Bernardino County
Ex Officio	Dr. Wayne Clark, CalMHSA President, Monterey County

The FC met by teleconference on May 7, 2013. The following items were included on the agenda and the discussion is included in the attached draft committee minutes:

1. CalMHSA Treasurer's Report as of December 31, 2012 *(see Agenda Item 7 – Consent Calendar)*
2. CalMHSA Treasurer's Report as of March 31, 2013 *(see Agenda Item 7 – Consent Calendar)*
3. CalMHSA Financial Statements for the Quarters Ended December 31, 2012 and March 31, 2013 *(see Agenda Item 7 – Consent Calendar)*
4. CalMHSA Investment Update *(presentation, reference materials attached)*
5. CalMHSA Annual Revenue and Expenditure Report – Proposed Budget June 30, 2014 *(see Agenda Item 9.C – Annual Revenue and Expenditure Report – Proposed Budget June 30, 2014))*
6. George Hills Company Contract – Finance Committee Task Force Update
7. Discussion on Statewide Hospital Beds *(see Agenda Item 10.F – State Hospital Beds)*
8. Finance Committee Teleconference Calendar Fiscal Year 2013–14

See discussion in the attached Draft Finance Committee Minutes for more information on the above items.

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- Draft May 7, 2013 Finance Committee Minutes
- Presentation Topics – John T. Liddle, Morgan Stanley
- Projected Monthly Income – Summary
- Account – Executive Summary
- Finance Committee Teleconference Calendar Fiscal Year 2013–14

PROGRAM MATTERS
Agenda Item 10.A

SUBJECT: Report from CalMHSA Program Director – Ann Collentine

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BACKGROUND AND STATUS:

CalMHSA Program Director, Ann Collentine, will provide general information and updates regarding the Statewide Prevention and Early Intervention Projects.

Implementation Status

- Stigma and Discrimination Reduction
- Suicide Prevention
- Student Mental Health

Training/Technical Assistance and Capacity Building

Evaluation

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- CalMHSA Program Director's Update Report
- Each Mind Matters Media Clips
- Following President Obama's Mental Health Summit, California Spotlights Efforts to bring Mental Illness "Out of the Shadows" (Press Release)

Program Matters
Agenda Item 10.B

SUBJECT: Report from CalMHSA Advisory Committee- Maureen Bauman

BACKGROUND AND STATUS:

The CalMHSA Advisory Committee held a meeting on May 9, 2013, in Sacramento. The Advisory Committee discussion focused on the following:

- Administration of the SDR Consortium *(see Agenda Item 10.C)*
- Plan Update- Proposed Contract Amendments for Remaining Stigma and Discrimination Reduction (SDR) Contractors (*see Agenda Item 10.D*)
- Enhancing Efforts to Reduce Disparities – Supporting Cultural Responsiveness *(see Agenda Item 10.E)*
- Strategic Planning Framework

  Staff requested feedback from the Committee and will continue the discussion on planning and plan development during committee meetings on July 11, September 12 and November 15, 2013. Staff anticipates the CalMHSA Board of Directors will approve a PEI Statewide Plan at their December 12, 2013 meeting. The plan will then be taken to local members' counties for consideration of allocating local PEI funds to sustain PEI Statewide Initiatives.
- CalMHSA received a letter of resignation from Advisory Committee Co-chair, Joseph Robinson. Mr. Robinson was recently hired as the Program Manager for the SDR Consortium Project and resigned from the Advisory Committee due to potential conflict of interest.

  CalMHSA is currently recruiting applicants to fill the position vacated by Mr. Robinson.

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- Advisory Committee Stakeholder Position Recruitment Posting

ADMINISTRATIVE MATTERS
Agenda Item 10.C

SUBJECT: SDR Consortium Administration

BACKGROUND AND STATUS:

The purpose of the Stigma and Discrimination Reduction (SDR) Consortium program is to bring together diverse perspectives to review efforts of the overall SDR component in order to support consistent messaging that reflects the values of resilience, recovery and wellness. Due to its diversity, the Consortium is also designed to reach and network with key partners in SDR efforts, such as educators, primary care providers, law enforcement, veterans and others. Consortium members are from all over the state and can provide input from local communities as well as support the local dissemination of SDR efforts and tools. The Consortium provides recommendations and takes action to support smaller scaled efforts at local and regional levels. All of this work is guided by their Strategic Work Plan.

Timeline and Current Status

- The original budget for the SDR Consortium from the approved Work Plan was $1.5 million.
- CalMHSA was unable to execute a contract with California Network of Mental Health Clients, the organization that was selected through the competitive RFP process, to administer the contract in the fall of 2011.
- CalMHSA's board supported a transition plan, which brought in a consultant to build and then staff the work product of the SDR Consortium with CiMH providing administrative support from the fall of 2011 through the fall of 2012. During this time, $300,000.00 of the contract was expended.
- During this time the membership created a Strategic Work Plan that identified five outcomes for the consortium to achieve by June 30, 2014 (or upon conclusion of the contract with CalMHSA).
- CalMHSA staff, with direction from the Board and the Consortium, created a Request for Interest (RFI) for a consumer-run organization with statewide voice to take over the administration of the Consortium. After a competitive review process, Mental Health Consumer Concerns (MHCC) was awarded a contract for the remaining funds—$1.2 million. The contract was signed December 10, 2012.
- To support a smooth transition, the interim consortium program manager provided some support and training to MHCC through February 2013.

- CalMHSA terminated Mental Health Consumer Concerns (MHCC) contract on Monday, April 8th due to performance failure. The decision to terminate the contract came after a performance improvement plan (PIP) was provided to MHCC on April 2nd. In discussions with the interim executive director and representatives of their board, it was determined that MHCC could not comply with a Performance Improvement Plan (PIP) and there was mutual agreement with CalMHSA that the contract should be terminated immediately. CalMHSA appreciates that MHCC has been collaborative and cooperative in this process.

Key Issues

- Roughly $1 million remains in the contract to implement the activities of the Strategic Work Plan within a less than 14-month-timeframe (April 2013–June 2014). The budget supports an "up to" 30 member body that meets quarterly in person with a variety of workgroup meetings via webinar or conference call during the remaining months of the year. Staffing includes program support with needed expertise in SDR work to staff the five consortium workgroups, facilitation of a statewide coalition, and administrative support to support compliance with CalMHSA reporting and the RAND evaluation, necessary IT systems and tools, and management of travel, stipends and meeting planning.

- The time to select another contractor and get the organization up to speed with all of the activities of the CalMHSA PEI statewide projects and how they relate to the work of the SDR consortium, including training for compliance with CalMHSA reporting requirements, would be at least three to six months.

- Based on previous solicitations for qualified contractors, there might not be a pool of qualified candidates.

- Consortium members are fatigued and concerned by all of the transition and are seeking CalMHSA's involvement to provide stability and swift action so that the Strategic Work Plan can be implemented within the short remaining timeframe.

STATUS AND NEXT STEPS:

To expedite meeting deliverables with quality and efficiency, CalMHSA staff recommended to the CalMHSA Executive Committee at their May 9th meeting that direct administration of the SDR Consortium begin effective immediately. Due to the need to expeditiously move forward on the Consortium work, the Executive Committee unanimously approved the following recommendation:

Authorize conduct of SDR consortium by CalMHSA staff effective immediately. Authorize contract for up to $1,000,000 between CalMHSA and staff employer George Hills Company for such work, with provisions similar to the prior contracts negotiated with MHCC. The contract's administrative fee shall not exceed standard practice with other CalMHSA contractors. Authorize Wayne Clark and Scott Gruendl to negotiate and sign contract with George Hills Company consistent with Board's authorization.

The intent is not for CalMHSA to continue to administer this program after June 2014, but to stabilize and strengthen it. CalMHSA's administration would build towards a transition effective after June 2014 to sustainable leadership of the SDR Consortium by a qualified organization that can provide expertise and statewide voice for those with lived mental health experience consistent with the California Statewide Plan to Reduce Stigma and Discrimination. This recommendation has been vetted and supported by the SDR Consortium members as of April 23, 2013. The scope of tasks includes:

- Assuming the all management, administration and organizational functions of the existing SDR consortium, including compliance with reporting requirements and the independent statewide evaluation conducted by RAND,

- Ensuring statewide voice on the critical impact of stigma, resulting discrimination, and disparities experienced by individuals, families, and communities,

- Maintaining and supporting the current configuration of the consortium's membership that prioritizes and is reflective of diverse sectors and disciplines, in addition to the mental health field; and individuals representing consumers, family members and parents,

- Fulfilling the networking, coordination and collaboration role of the consortium by staffing workgroups, webinars, meetings and supporting the statewide dissemination and local use of Each Mind Matters and other educational tools and resources, and

- Implementing the Consortium's Strategic Work Plan through activities and tasks that support the achievement of the outcomes identified in the work plan.

Staffing Plan:

- The administration of the SDR Consortium began with the hiring of Joseph Robinson as Consortium Program Manager and Aubry Lara as Program Coordinator. Additionally an administrative assistant and clerical/information technology assistant will are in the process of being hired to execute the work of the SDR Consortium in an expedited manner.

- Seek to retain consultation services of the former interim program manager, Adele James, in a reduced role as the consortium's facilitator. SDR Consortium members trust and respect Ms. James. Ms. James facilitation provides continuity and allows for new program staff to focus on staffing workgroups and accomplishing needed tasks. Ms. James has expressed interest and availability.

- Seek to develop consultation contracts with organizations or experts, as needed, to provide subject matter expertise to conduct the tasks identified in the Strategic Work Plan and to act as a link to local/regional SDR activities.

RECOMMENDATION:

None, information only.

REFERENCE MATERIAL(S) ATTACHED:

- Stigma and Discrimination Reduction Consortium Strategic Work Plan

PROGRAM MATTERS
Agenda Item 10.D

SUBJECT: Plan Update Contract Amendments

BACKGROUND AND STATUS:

As approved by the CalMHSA Board on August 9, 2012, the CalMHSA Plan Update shifted an additional $14.2 million into program activities, resulting in approximately:

- $3.6 million for Suicide Prevention,
- $5.3 million for Student Mental Health and,
- $5.3 million for Stigma and Discrimination Reduction, plus approximately $2.2 million held on reserve from the approved First Work Plan Amendment.

These new program funds strengthen the existing, approved statewide PEI programs, and are consistent with Key Principles for Funding Allocations vetted through the CalMHSA Advisory Committee, Board and the MHSOAC.

- In October 2012, current providers of PEI Statewide programs were invited to submit proposals to enhance the scope of their contracts, in keeping with these adopted principles.
- Proposals were reviewed and scored by a review panel including CalMHSA members, CalMHSA Advisory Committee stakeholder members, cultural competency experts, and CalMHSA staff.
- Factors considered in the review process included: adherence to the principles, reasonableness of the program design and budget, capacity to implement by June 2014, and contract performance to date. Review panels recommended approval of proposals which, in many cases, were contingent upon modifications to proposals.
- Program staff reviewed programs in aggregate to identify opportunities to increase coordination and synergy (e.g., buying power, leveraged resources) across programs and initiatives.
- It is important to note that the level of funding for each program is contingent upon contract negotiations and modifications requested by the review panels. Any available funds unspent in the Plan Update will be reserved for future program activities.
- Allocations maintain overall consistency in the proportion of funds allocated to each initiative, within one percentage point.

STATUS:

At this point in time almost all contract amendments have been executed consistent with the process above. There were two unique circumstances pertaining to SDR contractors, The Mental Health Association in California (MHAC) and The Community Clinics Initiative – Integrated Behavioral Health Care Project (CCI-IBHP). These contractors had to undergo a second review process for different reasons. The review process was consistent to the one outlined above and took place in April 2013.

1. In December 2012, the CalMHSA Board voted for the funding available to MHAC ($750,000.00) is set aside pending review panel approval of a resubmitted proposal. MHAC submitted a revised proposal which was reviewed by the review panel.

2. In December 2012, the CalMHSA Board approved CCI-IBHP's original proposal as recommended, but the organization only requested 50% of the funds available to them under the Plan Update formula. After identifying appropriate unmet needs that are consistent with the plan update principles and forging a partnership with a new subcontractor, California Association of Social Rehabilitation Agencies (CASRA), CCI-IBHP requested remaining available funds, ($374,100.00). CCI-IBHP submitted a revised proposal to request the additional available funds which was reviewed by the review panel.

The table below provides information regarding current contract funding levels, requested additional funding, key deliverables, general comments from the review panel and recommendations.

Program Partner	Current Funding	Amend Contract Up To	Key Deliverables	Comments	Recommendation
MHAC Values, Practices, and Policies: Promoting Mental Health in the Workplace	$3,000,000	$750,000	• Seek augmented funding to increase resources to Regional Hubs, which are mostly non-profit Mental Health of America (MHA) chapters. The additional funds will support increased reach and scope of local chapters in their implementation of the Wellness Works Program. • Funds will also expand MHAC's capacity to administer the statewide effort including increased collaboration with counties, trainings, material distribution and learning dissemination. • Some training will be culturally adapted/ translated/conducted in Spanish and Chinese.	Comments • Appreciated that the majority of funds went to affiliates/"regional" hubs at the local level • Appreciated the effort to adapt tools for Spanish and/or Chinese employers Modifications • Contract Manager will review Quarterly Program Report (Due April 30, 2013) and Deliverables prior to contract negotiations to assess capacity and performance • Contract negotiations should determine and then specify regional hubs with capacity to provide the amount of trainings identified in the proposal in a region • Provide clarification on Wellness Works! translation in Spanish and/or Chinese • Must demonstrate a plan for outreach, engagement, and dissemination with counties regarding the impact of deliverables on local communities	Approve with significant modifications
CCI-IBHP Values, Practices, and Policies: Promoting Integrated Health	$3,375,900	$374,100	Through a partnership with CASRA, CCI-IBHP will foster the utilization of peers with lived experience in integrated behavioral health settings through: 1. development of a business case for involving peers in integrated	Comments • Will include the use of racially and ethnically diverse peers • Appreciated commitment to data collection and program evaluation that	Approve with modifications

			setting, including data that demonstrates the effectiveness of peer inclusion, 2. identifying and assessing models currently being used, and 3. Creating a tool kit for communities and organizations interested in involving peers from financing to performance assessment. The products above will be enhanced through partnerships with consultants with expertise with rural communities and diverse racial, ethnic and cultural communities. Trainings will be provided for the products use at the community-level.	will have long-term impact • Low administrative fees • Support for local organizations to use this information at the local level Modifications • Need clarity on how racially and ethnically diverse individuals will be included in the project • Explore and/or resolve how this information gets delivered if there's a lack of capacity at the local level, particularly a lack of a CBO with members and/or leadership who have lived experience	

While contractors have requested the above funding levels, the awarded contract level will depend upon the direction given by the Board and the willingness of current providers to modify their proposals and/or improve contract compliance or performance as requested. Approval of this recommendation by CalMHSA's Board confers no rights on the part of the proposing parties.

RECOMMENDATION:

Authorize staff to negotiate amended contracts for Program Partners, as recommended by the Advisory Committee, and authorize the Executive Director and President to execute such amendments on behalf of CalMHSA.

REFERENCE MATERIAL(S) ATTACHED:

- None

PROGRAM MATTERS
Agenda Item 10.E

SUBJECT: Enhancing Efforts to Reduce Disparities – Supporting Cultural Responsiveness

BACKGROUND:

The Mental Health Services Act (MHSA) brought issues of mental health disparities to the forefront and prioritized the improvement of mental health care to underserved ethnic and cultural communities. Consistent with the MHSA and CalMHSA principles, statewide PEI programs should promote cultural competency. To address this objective, in July 2012, CalMHSA entered into contract with the California Institute for Mental Health (CiMH) to conduct a cultural competence assessment of CalMHSA and its program partners to help identify strengths and gaps to further enhance efforts to reduce disparities.

Phase one of this project has been underway for the last eight months and is now concluded. In this phase a needs assessment of CalMHSA and its 25 program partners was conducted by CiMH. CiMH assessed the following areas regarding cultural competency with each program partner: organizational values/policies, evaluation and monitoring, communication and language access, workforce diversity, community participation, facilitation of a broad service array, and organization resources. In order to gather the necessary information, the needs assessment was given three parts: review of materials including but not limited to scope of work, quarterly reports, and deliverables, an interview with the organization, and an online survey.

The information gathered was analyzed and each program partner was provided with a summary of strengths and opportunities for improvements through training and technical assistance. A cumulative analysis of the strengths and additional needs to support enhanced efforts to reduce disparities is provided in a final recommendations report that was submitted to CalMHSA for review in April 2013. The full report is attached as a reference document.

Final Report Findings

Overall the analysis noted a demonstration by program partners which affirmed commitment to cultural competence and responsiveness. While program partners are extremely diverse in their own capacities ranging from small non-profits to large system partners, they are similar to the behavioral health system at large, which is eager but challenged in developing preparedness to meet the wide racial, ethnic and cultural diversity of California's population. According to the U.S. Census, over 60% of Californians identify as a member of an ethnic or racial group or belong to more than one race or ethnicity. A step that can be taken to develop this preparedness is to build strong organizational cultural competence and the capacity to develop culturally responsive products and services that would yield high impact in un-served, underserved or inappropriately served ethnic, racial and cultural communities.

From the assessment several themes emerged, including: challenges regarding the development of relationships with communities of color, implementation of language access services, data collection, and culturally appropriate adaptations of products and services. The following

recommendations are organized into two categories: strategies to enhance cultural responsiveness of products and services and strategies to improve organizational cultural competence.

Recommendations to enhance cultural responsiveness of products and services

1. Utilize culturally appropriate community-defined practices to adapt products and services for targeted racial and ethnic populations

2. Improve strategies for collecting and analyzing demographic data by race, ethnicity, sexual orientation and gender identity

3. Enhance linguistic competence and language access by providing appropriate translation and interpretation services

4. Develop culturally appropriate strategies for assessing the impact of project implementation in targeted un-served, underserved and inappropriately served communities

Recommendations to improve organizational cultural competence

1. Strengthen and/or build formal relationships with community members and community-based organizations for the purpose of institutionalizing relationships with un-served, underserved, and inappropriately served communities

2. Create a mechanism for regular, on-going self-assessment of the organizational cultural competence and capacity to be responsive to racial, ethnic, linguistic and cultural populations

3. Continually assess individual staff development needs and skill-sets necessary to ensure cultural responsiveness

STATUS:

CalMHSA staff has asked CiMH to provide recommendations for immediate training and technical assistance to strengthen the cultural responsiveness of program partners and to enhance efforts to reduce disparities for diverse racial, ethnic and cultural communities based on the assessment results and analysis. Three overarching training and technical assistance needs emerged:

- Improve skills in outreach and engagement strategies,

- Enhance understanding of cultural differences and distinctions within suicide prevention, stigma reduction and student mental health, and

Develop strategies to adapt and incorporate the cultural competency skills into daily program delivery and overall organizational structure.

On May 9, 2013, the CalMHSA Advisory Committee approved the presentation of the recommendations being brought before the board today.

RECOMMENDATIONS:

1. Authorize staff to extend contract with CiMH for up to $100,000 to coordinate and deliver expedited training and technical assistance based on findings from the assessment to enhance efforts to reduce disparities.
2. Approve contracting with interested California Reducing Disparities Project (CRDP) contractors, or their identified partners, to develop tool kits or other relevant resources, based on the findings of their population reports and extensive knowledge of underserved communities, that identify key cultural considerations for Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health efforts no later than the third quarter of FY 13-14 for a total of no more than $150,000.

REFERENCE MATERIAL(S) ATTACHED:

- Enhancing Efforts to Reduce Disparities through the Statewide Mental Health Services Act Prevention and Early Intervention Program

PROGRAM MATTERS
Agenda Item 10.F

SUBJECT: State Hospital Beds

BACKGROUND AND STATUS:

Below is a chronology of significant events regarding the planning and development around state hospital beds.

- June 14, 2012 – Staff is moving forward with the direction provided on one of the priority items at the Strategic Planning Session (April 13, 2012)regarding staff working with CMHDA in exploring the JPA acting on behalf of member counties in the annual purchase contract for State Hospital Beds. In addition, the Board approved a budget of up to $100,000.00 for planning and development related to this work, which would be billed to participating counties.
- August 10, 2012 – Staff convened a short-term Work Group that includes members and/or appointed county staff and CMHDA in an effort to identify the various responsibilities and functions between counties, CalMHSA, hospitals and initial county needs assessment.
- December 13, 2012 – The Work Group provided the CalMHSA Board with a full update on current activities to include preparation of a draft Participation Agreement, which is intended to describe the extent of the Bed Services Program and most importantly signify the JPA's authority to contract on behalf of counties.
- January 15, 2013 – The Work Group and CalMHSA had their first meeting with DSH to discuss their MOU distributed to counties in November 2012 and recommendation changes. DSH agreed to distribute the MOU to all counties for a 30 day comment period on recommended changes, followed by their consideration of recommendations.
- May 31, 2013 – Staff issued a memo to participating members as it relates to work performed in the planning and development of a contract with DSH for the procurement of state hospital beds. In addition, staff provided the members with cost and allocation for FY 12/13 with notice of an invoice to be issued for such services.

The Work Group has increased the series of meeting convened to include three additional meetings with DSH between January and May 2013.

STATUS OF OPEN ITEMS:

1. MOU
2. County Counsel Association discussions
3. CalMHSA role, if any, for 2013-14. Participation Agreement indicates potential role, but will be adjusted when more known.

4. Budget for Planning and Development and Operating for 2013-14. Will be adjusted when more known.

To date, the Work Group, CMHDA and CalMHSA, have met with DSH four times, with the last meeting on June 3, 2013. At this meeting the following items are under discussion, and/or have reached consensus:

Section	Description	Status
I. Recitals	Added: All hospitals shall comply with responsibilities noted for DSH in this agreement.	Consensus
II. Terms and Conditions	**B. County Referred Patients**	Under discussion
	C. Description of Covered Hospital Services	Under discussion
	D. Admission & Discharge Procedures	Under discussion
	E. Bed Type Transfers	Under discussion
	F. Penalties	Under discussion
	H. Coordination of Treatment/Case Management	
	2. Case manager/team Information available on-line	Consensus
	K. Bed Usage Commitment	Under discussion
	L. Bed Payment	Under discussion
	M. Utilization Review – Hospital Operations	Consensus
	N. Records	
	2. Financial Records	Consensus
	O. Revenue	Under discussion
	P. Inspections and Audits	Consensus
	Q. Notices	Consensus
III. Special Provision	**A. No intent to amend or waive any statutory provisions**	Consensus
	C. Indemnification (mutual indemnification)	Under discussion
	Note: see attached redlined MOU for details.	

Doug Alliston, counsel for CalMHSA, has been in ongoing discussions with the County Counsel Association in an effort to receive their input on recommended changes to the MOU.

In a recent meeting with the Work Group, they re-confirmed their desire to work with the JPA as one voice to continue negotiations for a joint contract and operationalize DSH beds with CalMHSA for FY 2013-14. The draft Participation Agreement indicates a potential role for the JPA with the understanding that adjustments will be made as more information is available.

In addition, staff projected planning, development and operation costs for FY 2013-14 with the understanding these numbers will fluctuate as we learn more. (See attached projections.)

Additional effort would be completion of a mutually acceptable MOU, redefining and presenting the operational plan and consideration of reviewing alternatives for DSH.

NEXT STEPS:

- Response by counties or JPA for Enclosure B—number of beds
- Follow up meeting with Work Group to discuss DSH proposed changes
- CMHDA to meet with the Department of Finance
- Counties to take to their boards of supervisors for approval for potential expenditures for 2013-14
- Work Group to meet with DSH in July to hopefully finalize MOU
- Decision on MOU—individual or joint
- Extent of operationalizing any responsibilities on a joint basis, at which time a budget can be finalized

RECOMMENDATIONS:

Approval to continue negotiations for a joint contract and operationalize the DSH Beds with CalMHSA for FY 2013-14.

REFERENCE MATERIAL(S) ATTACHED:

- Planning, Development and Operation Cost Projections
- Proposed State Hospital Service Program Administrative and Management Budget (December 2012 Board Agenda)
- Draft Participation Agreement (LA County)

ADMINISTRATIVE MATTERS
Agenda Item 11.A

SUBJECT: Executive Committee Election

BACKGROUND AND STATUS:

On June 30, 2013, the terms for the four officers and five of the regional representatives on the Executive Committee will end. The CalMHSA Bylaws state that the Board will elect, by majority vote, a new slate of officers and executive committee members at the last board meeting of the fiscal year.

The nominated slate of officers and committee members is as follows:

Position		Member	Term Length	Start Date	End Date
President		Wayne Clark, Monterey County	2 years	7/1/2013	6/30/2015
Vice President		Maureen Bauman, Placer County	2 years	7/1/2013	6/30/2015
Secretary		CaSonya Thomas, San Bernardino County	2 years	7/1/2013	6/30/2015
Treasurer		Scott Gruendl, Glenn County	2 years	7/1/2013	6/30/2015
Bay Area	#2	Jo Robinson, San Francisco City & County	2 years	7/1/2013	6/30/2015
Central	#1	Brad Luz, Sutter/Yuba Counties	2 years	7/1/2013	6/30/2015
Los Angeles	#1	Marvin Southard, Los Angeles County	2 years	7/1/2013	6/30/2015
Southern	#2	Alfredo Aguirre, San Diego County	2 years	7/1/2013	6/30/2015
Superior	#1	Karen Stockton, Modoc County	2 years	7/1/2013	6/30/2015

At the April 12, 2013 board meeting, a nominating committee was appointed consisting of Dr. Wayne Clark, Dr. Karen Baylor and Anne Robin. The nominating committee requested nominations from the full board, with instruction to make nominations in writing by May 12, 2013. Additional candidate(s) may be nominated at the time of the meeting, provided the candidate(s) meet the requirements set forth in Sections 5.4 and 6.1 of the Bylaws. As directed by the CalMHSA Bylaws, staff distributed the slate of candidates to the full board in writings seven (7) days prior to the last board meeting of the fiscal year on June 6, 2013.

RECOMMENDATION:

Election of officers and Executive Committee members representing the five CMHDA regions to a two year term ending June 30, 2015.

REFERENCE MATERIAL(S) ATTACHED:

- None

ADMINISTRATIVE MATTERS
Agenda Item 11.B

SUBJECT: Strategic Planning Session Follow-up

BACKGROUND AND STATUS:

At the CalMHSA Strategic Planning Meeting on April 12, 2013, the CalMHSA Board validated the desire of the Board to continue funding PEI Statewide Projects. At the time, Board members were provided with a timeline and a framework regarding the development of a PEI Statewide Projects Sustainability Plan for Board consideration at the December 2013 Board Meeting. Additionally, members requested early preliminary projections of annual cost per county at the next Board meeting. This document is attached. A workgroup of Board members with a member from each CMHDA region is being formed to provide guidance on the plan development as it progresses. To date Los Angeles, San Diego and Sacramento counties have agreed to participate. Staff is awaiting responses from invitations which were extended for Bay Area and Superior Region representatives.

In addition, staff is continuing to refine a Return on Investment handout for each county which will provide a glimpse of initial impact of PEI Statewide Projects activities for that county. Board members confirmed that an easy to read and understand document will assist local stakeholders assess the value of activities to date.

As part of their discussion the board was presented with 18 potential projects on which to vote by a show of hands.

Project Name	Yes	No	Maybe
State Hospital Beds	16	0	3
Suicide Prevention Program	15	2	4
Getting grant funding (e.g., SAMHSA)	14	1	5
Workforce Education Training (WET)	12	7	0
Database Management	11	1	8
MHSA Housing Program	7	10	3
Litigation Pool Management	8	1	12
Communication Program	6	4	10
EPSDT	6	11	3
Collective Addressing IT Program Changes	5	3	11
Procurement of Services	5	8	7
Individual and Collective Mental Health Projects	4	4	10
Drug-Medical (development of regional approaches)	4	9	7
Fiscal Risk Pools	4	10	4
AB 109 (Glenn County)	3	12	3
Affordable Care Act	2	2	17
Health Benefit Exchange	2	9	10
Assurance of Statewide Reach Programs	1	11	7

To better analyze the board's vote, staff has also reviewed the results by combining all affirmative votes of yes and maybe to get a better sense of potential overall interest.

Project Name	Yes/Maybe	No
Litigation Pool Management	20	1
State Hospital Beds	19	0
Getting grant funding (e.g., SAMHSA)	19	1
Database Management	19	1
Suicide Prevention Program	19	2
Affordable Care Act	19	2
Collective Addressing IT Program Changes	16	3
Communication Program	16	4
Individual and Collective Mental Health Projects	14	4
Workforce Education Training (WET)	12	7
Procurement of Services	12	8
Health Benefit Exchange	12	9
Drug-Medical (development of regional approaches)	11	9
MHSA Housing Program	10	10
EPSDT	9	11
Fiscal Risk Pools	8	10
Assurance of Statewide Reach Programs	8	11
AB 109 (Glenn County)	6	12

At each year's strategic planning session, staff envisions the board will select three projects for staff to analyze and report back for approval or abandonment. If, during the subsequent year, a more vital project is identified, the board or Executive Committee may make changes to the list. But to begin with, with assistance from the CalMHSA officers, staff has developed the following list of seven (7) projects for analysis and potential development during fiscal year 2013-14:

Project Name	Yes	No	Maybe
State Hospital Beds	16	0	3
Suicide Prevention Program	15	2	4
Getting grant funding (e.g., SAMHSA)	14	1	5
Workforce Education Training (WET)	12	7	0
Database Management	11	1	8
Litigation Pool Management	8	1	12
Individual and Collective Mental Health Projects/Joint Purchasing	4	4	10

RECOMMENDATION:

Approval for staff to analyze and report back on the recommended projects listed above.

REFERENCE MATERIAL(S) ATTACHED:

- Strategic Planning Framework
- Strategic Planning Process and Timeline
- Preliminary County Allocations Based on PEI Assignments

GENERAL DISCUSSION
Agenda Item 12.A

SUBJECT: Report from CalMHSA President – Wayne Clark

BACKGROUND AND STATUS:

CalMHSA President, Wayne Clark, PhD, will provide general information and updates on the following items:

- PEI Statewide Project Sustainability Workgroup Appointments
- General

RECOMMENDATION:

Discussion and/or action as deemed appropriate.

REFERENCE MATERIAL(S) ATTACHED:

- None

GENERAL DISCUSSION
Agenda Item 12.B

SUBJECT: Report from CalMHSA Executive Director – John Chaquica

BACKGROUND AND STATUS:

CalMHSA Executive Director, John Chaquica, will provide general information and updates regarding the JPA.

- Department of Health Care Services Contract
- Media Postings at www.calmhsa.org
- General

RECOMMENDATION:

Discussion and/or action as deemed appropriate.

REFERENCE MATERIAL(S) ATTACHED:

- None

Effective Suicide Prevention in Higher Education

Jerry Phelps, PhD, Monique Mendoza Crandal, PhD
and Reina Juarez, PhD

The tragedy of suicide among college students becomes more poignant in view of the promise their future holds. Recently, efforts to prevent suicide have increased on the national, state, county, local and private level. Psychologists play a major role in higher education suicide prevention.

The prevalence of psychological disorders among college students presents both a growing concern and an opportunity. As college students undergo a transition from family home to independence, psychologically vulnerable students with low social support may experience overwhelming levels of stress (Wilcox et al., 2010). Research on college student suicide has shown that one in 10 college students make a suicide plan, 18-24 year-olds think about suicide more often than any other age group, and peak risk for suicide attempts is in late adolescence and young adulthood (Jed Foundation, 2002). Suicide is the second leading cause of death for youth aged 18-25 (U.S. Public Health Service, 2001).

Rates of completed suicide, however, are lower for traditional-aged college students than for age-matched peers not attending college (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997). Researchers attribute these lower rates to the availability of more low or no-cost mental health services, increased peer support and advising, and the restriction of means due to substance and firearms restrictions on college campuses (Hass, Hendin, & Mann, 2003).

Stigma Reduction and Outreach Approaches

Multifaceted approaches are being successfully utilized in the higher education community on a variety of levels to address suicide prevention. Comprehensive suicide prevention necessitates a collaborative, community-wide approach that de-stigmatizes mental health, normalizes treatment, reinforces healthy lifestyles and other protective factors, and empowers staff, faculty and students to refer students who are exhibiting signs of suicide or other mental health concerns (Jed Foundation, 2006a).

Suicide prevention often starts with the messages that are communicated to college students. Guided by evidence-based recommendations for talking about suicide and mental health in a safe and effective manner, public awareness campaigns address both stigma reduction and outreach. The Suicide Prevention Resource Council (SPRC) offers safe messaging guidelines (Suicide Prevention Resource Council, 2006) that include emphasizing that suicides are preventable; outlining key warning signs and protective factors; stressing that the vast majority of those who die by suicide suffer from a treatable psychiatric illness and/or substance abuse disorder; and providing information on how to access treatment and where to find immediate assistance.

Utilizing non-clinical student support services to deliver educational messages reduces stigma and promotes protective factors. Trained student peers play an important role in promoting suicide prevention on college campuses. Groups such as Active Minds, peer educators, and student mental health advisory boards deliver paraprofessional services such as stress management workshops and biofeedback, outreach programs such as depression awareness days and wellness fairs, and marketing educational materials. Increasingly, other key student leaders also promote mental health and suicide awareness and education.

Additionally, parents and family members play a crucial role in suicide prevention. The Jed Foundation (2006b) reports that almost two-

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Representation of Psychotherapists in Board of Psychology Investigations and Hearings

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thirds of students will turn to family in times of emotional distress. Parent and family outreach programs deliver information on entering college with existing mental health conditions, adjustment to college life, how to notice distress in your relative, and campus mental health resources.

Training and Protocols

Counseling centers and university psychologists often lead efforts to identify and refer at-risk students to mental health treatment professionals. 80% of college students who die by suicide are not known to campus mental health professionals (Gallagher, 2009). In response to this disconnect, the Jed Foundation and the Suicide Prevention Resource Center recommend collaboration and enhanced communication amongst the campus community to identify students who may be at risk for suicide (Jed Foundation, 2006a; SPRC, 2004).

To help others on campus detect students of concern, psychologists create, deliver, manage, and assess specialized training programs for "gatekeepers." These programs are designed to assist faculty, key staff, and student leaders to identify students in distress, offer support, determine where to refer for mental health treatment, and communicate with relevant professionals.

In addition, campuses have also developed policies and protocols to identify, refer, manage, treat, and communicate with students at-risk for suicide or highly distressed (Jed Foundation, 2006a). The Organization of Counseling Center Directors in Higher Education (OCCDHE), serves counseling center directors from California public and private four-year colleges and universities and provides a useful forum for California higher education institutions to consult about relevant training, prevention and treatment issues.

Treatment

Most institutions of higher education have counseling centers dedicated to serve the needs of students and to create easy-access to services. Counseling center psychologists consult, deliver short-term treatment, provide urgent evaluation and crisis counseling, and make referrals. Recommendations for addressing suicide prevention in the treatment of students include screening programs, on-site counseling centers and medical services, emergency services, and referrals to mental health providers in the community (Jed Foundation, 2006a). Counseling centers establish relationships and memorandums of understanding for referrals to community providers, out-patient treatment programs, and in-patient psychiatric facilities. These referral options ideally specialize in issues related to college students that cannot be managed in short-term treatment such as severe depression, bipolar disorder, psychotic conditions, anorexia and substance dependence.

Primary care providers play an important role in suicide prevention. According to SPRC, in the year prior, only 32% of individuals who died by suicide had contact with mental health services, but 75% of them saw a primary care provider (Luoma, Martin & Pearson, 2002). Counseling centers work closely with on-site Student Health Services to collaborate in treatment. Collaborative care often includes shared electronic medical record systems, interdisciplinary team management of high risk students (eating disorder and substance abuse treatment teams), joint training on mental health management, and shared policies in the management of mental health issues. Counseling centers also develop protocols for managing high-risk students such as devel-

AWARDS OF HONOR 2013

CPA annually honors psychologists and others for their commitment to the betterment of the Association, the profession and public mental health. These awards were presented at the CPA Annual Convention in April 2013.

Lifetime Achievement
R.K. Janmeja (Meji) Singh, PhD

Silver Psi
Mary Malik, PhD

Bronze Psi
Takisha McNeil Corbett , MA

Distinguished Contribution to Psychology as a Profession
Michael G. Ritz, PhD

Distinguished Contribution to Psychology
Frederic M. Luskin, PhD

Distinguished Scientific Contribution to Psychology
Bruce F. Chorpita, PhD

Distinguished Humanitarian Contribution
Ira Heilveil, PhD

Jerry Clark Advocacy Award
David M. Lechuga, PhD, ABPP

Student Advocacy Award
J.B. Robinson, MA

Outstanding CPA Chapter
San Gabriel Valley Psychological Association

Outstanding CPA Chapter Newsletter
Santa Clara County Psychological Association

Division of Clinical and Profession Practice (I)
Award for Distinguished Service
Sallie E. Hildebrandt, PhD

Division of Education and Training (II)
Awards for Distinguished Service:
David J. Martin, PhD

Division of Clinical Psychopharmacology (V)
Award for Distinguished Service
John Preston, PsyD, ABPP
David Silverman, PhD

Division of Diversity and Social Justice (VII)
Award for Distinguished Service
Jorge Wong, PhD

oping safety plans, offering higher levels of care, engaging significant others, collaborating with university police for involuntary hospitalization, and facilitating bridge care and wrap around services after hospitalizations.

At many universities, key administrators, usually Deans of students, are the central clearinghouse of information about students of concern and, in consultation with others, make decisions about administrative actions that need to be taken in the identification, referral and follow-up stages. Teams of mental health and other professionals develop protocols to inform administrators how to address issues concerning hospitalization, follow-up, emergency contacts, leaves of absence and managing the legal issues involved. These procedures are necessary so that university administrators may effectively comply with the appropriate university policy, privacy laws (including FERPA and HIPAA), Americans with Disabilities Act, and state, local and federal laws. Universities are also developing standardized protocols for screening, identification, treatment and referral using measures such as the Patient Health Questionnaire 9 (Kroenke & Spitzer, 2002) and the Interactive Screening Program (Haas, et al., 2008).

California Initiatives

In 2011, the California Mental Health Services Authority (CalMHSA), funded by the voter approved Mental Health Services Agency (funded by Proposition 63), awarded the three California public systems of higher education funding to enhance their efforts toward suicide prevention strategies, stigma and discrimination reduction, and mental health training for students, faculty, and staff. The three funded systems include the California State University system, the California Community Colleges, and the University of California. These awards strategically fund various aspects of recommended, evidenced-based prevention and intervention strategies to better assist college students in getting them the services they need.

CalMHSA awarded the University of California (UC) $6.9 million to support prevention and early intervention strategies that address the mental health needs of UC students. UC proposed a two-phase process in implementing these funds. Phase I includes developing and enhancing campus programs and services for peer-to-peer support, faculty/staff/student training, and suicide prevention. Phase II includes strengthening UC's relationship with the other California higher education systems (California State University (CSU) and California Community Colleges (CCC)) by collaborating on projects that increase access to services for all students within the systems, provide outreach, and extend resources statewide. Furthermore, counseling centers and psychologists are furthering research, creating protocols, and developing and implementing best practices to respond to the campus community and public health mandate of suicide prevention.

California institutions of higher education, with support from Proposition 63 funds, are taking necessary steps to establish comprehensive and collaborative mental health care for their campus communities. These services are being evaluated and presented to assist other universities implementing similar programs nation-wide.

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Jerry Phelps, PhD *(jerryphelps@ucsd.edu) is a Clinical Psychologist with the University of California (UCSD), San Diego Counseling and Psychological Services and Assistant Clinical Professor with the UCSD School of Medicine. He is a consultant, speaker and trainer for higher education and health systems. Areas of expertise include: suicide prevention, motivational interviewing, positive psychology, substance abuse, and wellness and health promotion. He has consulted on grants from the NIH, NIDA, ED, CDCR and the Jed Foundation.*

Monique Mendoza Crandal, PhD *(mmmendoza@ucsd.edu) is a Counseling Psychologist with UC San Diego Counseling and Psychological Services. With a focus on prevention, Dr. Crandal is actively involved in training, consulting in systems of higher education, and applied suicide research. Crandal's clinical and research interests include Latino/a college students, multicultural counseling, racial campus climate, motivational interviewing, strengths-based approaches to college student retention, coping, and engagement.*

Reina Juarez, PhD *(rjuarez@ucsd.edu) is the Director of Counseling and Psychological Services at the University of California, San Diego. She has practiced Clinical Psychology for 30 years in community and university settings. She leads prevention initiatives, serves as consultant to behavioral systems with diverse client populations, and formulates policies and procedures for the delivery of optimal mental health services, quality assurance and risk management. She combines contemporary positive psychology and wellness models with evidence based approaches.*

MINUTES

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CalMHSA)

STRATEGIC PLANNING SESSION AND BOARD OF DIRECTORS MEETING

Sacramento, California

April 12, 2013

MEMBERS PRESENT

Wayne Clark, PhD, CalMHSA President, Monterey County
Maureen F. Baumann, LCSW, CalMHSA Vice President, Placer County
Karen Baylor, PhD, MFT, CalMHSA Secretary, San Luis Obispo County
Scott Gruendl, MPA, CalMHSA Treasurer, Glenn County
Michael Kennedy, MFT, Bay Area Region Representative, Sonoma County
Brad Luz, PhD, Central Region Representative, Sutter/Yuba County
Rita Austin, LCSW, Central Region Representative, Tuolumne County
William Arroyo, MD, Los Angeles Region Representative, Los Angeles County
CaSonya Thomas, MPA, CHC, Southern Region Representative, San Bernardino County
Karen Stockton, PhD, MSW, Superior Region Representative, Modoc County
Anne Robin, MFT, Superior Region Representative, Butte County
Terence M. Rooney, PhD, Colusa County
Gary R. Blatnick, Del Norte County
Patricia Charles-Heathers, El Dorado County
Barbara LaHaie, Humboldt County
Gail Zwier, PhD, Inyo County
John Lawless, LCSW, Mariposa County (alternate)
Jaye Vanderhurst, LCSW, Napa County
Jenny Qian, MA, Orange County (alternate)
Jerry Wengerd, LCSW, Riverside County
Mary Ann Carrasco, Sacramento County
Alfredo Aguirre, LCSW, San Diego County
Jean Anderson, San Joaquin County (alternate)
Donnell Ewert, MPH, Shasta County
Madelyn Schlaepfer, PhD, Stanislaus County
Noel J. O'Neill, MFT, Trinity County
Joan Beesley, Yolo County (alternate)

ALTERNATES PRESENT

Dean True, Shasta County (alternate)

MEMBERS/ALTERNATES LISTENING IN

Debby Estes, LCSW, Madera County (alternate)
Meloney Roy, LCSW, Ventura County

MEMBERS ABSENT

Karyn Tribble, PsyD, LCSW, City of Berkeley
Mary Roy, MFT, Contra Costa County
Donna Taylor, RN, Fresno County
Michael Horn, MFT, Imperial County
Jim Waterman, PhD, Kern County
Mary Ann Ford Sherman, MA, Kings County
Kristy Kelly, MFT, Lake County
Barbara Pierson, Lassen County
Margaret Kisliuk, HHS, Marin County
Stacey Cryer, Mendocino County
Robin Roberts, MFT, Mono County
Michael Heggarty, MFT, Nevada County
Alan Yamamoto, LCSW, San Benito County
Jo Robinson, Bay Area Region Representative, San Francisco City and County
Stephen Kaplan, San Mateo County
Nancy Pena, PhD, Santa Clara County
Rama Khalsa, PhD, Santa Cruz County
Terry Barber, Siskiyou County
Halsey Simmons, MFT, Solano County
Jesse Duff, Tri-City Mental Health Center
Timothy Durick, PsyD, Tulare County

STAFF PRESENT

John Chaquica, CPA, MBA, ARM, CalMHSA Executive Director
Doug Alliston, Legal Counsel, Murphy Campbell Guthrie & Alliston
Kim Santin, CPA, CalMHSA Finance and Administration Director
Ann Collentine, MPPA, CalMHSA Program Director
Allan Rawland, Associate Administrator – Government Relations
Stephanie Welch, MSW, CalMHSA Senior Program Manager
Sarah Brichler, MEd, CalMHSA Program Manager
Laura Li, CalMHSA Program Analyst
Maya Maas, CalMHSA Executive Assistant
Michelle Yang, CalMHSA Executive Assistant
Jaikelle Meeks, CalMHSA Executive Assistant

MEMBERS OF THE PUBLIC

Manuel Jimenez, Merced County
Eric Douglas, Leading Resources, Inc.

Megan Kern, Leading Resources, Inc.
Mike Roth, Pascal/Roth
Sandra Goodwin-Naylor, California Institute for Mental Health (CiMH)
Doretha Flournoy-Williams, California Institute for Mental Health (CiMH)
Kirsten Barlow, California Mental Health Directors Association (CMHDA)
Theresa Ly, Education Development Center

1. CALL TO ORDER

The regular meeting and annual Strategic Planning Session of the Board of Directors of the California Mental Health Services Authority (CalMHSA) was called to order by President Wayne Clark, PhD, Monterey County at 8:35 a.m. on Thursday, April 12, 2013, at the Red Lion Hotel Woodlake Conference Center, located at 500 Leisure Lane, Sacramento, California.

President Clark welcomed those in attendance as well as those listening in on the phone. He turned the microphone over to the day's facilitator, Eric Douglas, Leading Resources, Inc. Mr. Douglas introduced himself and then reviewed the day's goals.

President Clark asked Laura Li, Program Analyst, to call roll in order to confirm a quorum of the Board.

2. ROLL CALL AND INTRODUCTIONS

Ms. Li called roll and informed President Clark a quorum had not been met. President Clark clarified discussion could take place; however, action could not be taken until a quorum was reached.

3. INSTRUCTIONS FOR PUBLIC COMMENT AND STAKEHOLDER INPUT

Doug Alliston, Legal Counsel, reviewed the instructions for public comment, including the process of public comment cards, and noted items not on the agenda would be reserved for public comment at the end of the agenda.

4. CMHDA STANDING REPORT

President Clark informed the Board he would wait to request an update on CMHDA matters until Kirsten Barlow of CMHDA arrived.

Action: ***None, information only.***

President Clark asked for a roll call of the Executive Committee. Ms. Li confirmed a quorum of the Executive Committee.

5. APPROVAL OF AGENDA AS POSTED (OR AMENDED)

President Clark called for approval of the agenda as posted and asked for comment from Board members. Hearing none, President Clark entertained a motion to approve the agenda as posted.

Action: ***A motion was made to approve the agenda as posted.***

Motion: ***William Arroyo, Los Angeles County***
Second: ***Karen Stockton, Modoc County***

Motion carried by unanimous consent.

Public comment was heard from the following individual(s):
None

6. CONSENT CALENDAR

President Clark acknowledged the consent calendar and asked for comment from Board members. Hearing none, President Clark entertained a motion to approve the consent calendar.

Action: ***A motion was made to approve the consent calendar.***

Motion: ***Anne Robin, Butte County***
Second: ***Scott Gruendl, Glenn County***

Motion carried unanimously.

Public comment was heard from the following individual(s):
None

7. Membership

A. County Outreach Report

Allan Rawland, CalMHSA Associate Administrator – Government Relations, provided an update on outreach efforts. Merced County is working through the membership process. Alameda County is scheduled to present their membership application to their board of supervisors on April 23, 2013. Following Alameda and Merced counties becoming members, about 98 percent of the California population would be covered by the JPA.

Action: ***None, information only.***

Public comment was heard from the following individual(s):
None

8. PROGRAM MATTERS

A. Report from CalMHSA Program Director – Ann Collentine

Ann Collentine, CalMHSA Program Director, gave a brief review of current Program Partner activities. Ms. Collentine shared President Clark and Stephanie Welch's article being published in the American Journal of Public Health's special issue on stigma and discrimination reduction. Additionally, CalMHSA's contract with Mental Health Consumer Concerns (MHCC) for program management of the Stigma and Discrimination Reduction Consortium has been terminated. Staff is working on a plan for moving forward, which will be presented to the Advisory Committee and the Executive Committee in May, with a final plan being presented at the June Board meeting.

Stephanie Welch, CalMHSA Senior Program Manager, gave an update on some of the marketing efforts. Tool kits containing t-shirts, stickers, ribbons, and lapel pins along with other materials will be distributed to the counties in preparation for May is Mental Health. The tag line being featured is "Each Mind Matters." The quantity of items provided will be determined by population. The tool kit will also contain a style guide to assist with some ideas for use of the materials provided. Some of the items will be available for purchase (at or near at cost) as well. The Directing Change PSA Contest Screening and Awards Ceremony will take place on Thursday, May 23, 2013 at the Crest Theater in Sacramento. Students from 142 schools statewide participated. Board members are encouraged to attend.

Action: ***None, information only.***

Public comment was heard from the following individual(s):
None

B. Report from the CalMHSA Advisory Committee – Maureen Bauman

Maureen Bauman, Placer County, who serves as CalMHSA Advisory Committee Co-chair, gave an update on the Committee's March 14, 2013 meeting. Runyon Saltzman & Einhorn provided an update on their inoculation campaign aimed at children ages 9 – 13. An interactive website will go live in the late summer of 2013. A school theater piece will launch in August 2013.

Action: ***None, information only.***

Public comment was heard from the following individual(s):
None

C. Student Mental Health Policy Workgroup

Ms. Collentine presented an overview of the Student Mental Health Policy Workgroup's recommendations for the inclusion of a mental health and wellness curricula in California credentialing programs. The Workgroup, which is convened by the California Department of Education as part of its contract with CalMHSA, will be presenting its

recommendations to the State Superintendent for Public Instruction Tom Torlakson. The Workgroup's recommendations were presented to the CalMHSA Advisory Committee on March 14, 2013. The Committee directed that the recommendations be presented to the full Board for endorsement.

Action: ***Endorse the Student Mental Health Policy Workgroup's March 8, 2013 Policy Recommendation.***

Motion: ***William Arroyo, Los Angeles County***
Second: ***Michael Kennedy, Sonoma County***

Motion passed unanimously.

Public comment was heard from the following individual(s):
None

D. Statewide Hospital Beds

John Chaquica, CalMHSA Executive Director, provided a brief overview of the Statewide Hospital Beds Workgroup progress to date. On January 24, 2013, a meeting was held with the Department of State Hospitals (DSH) that led to an open comment period on the Memorandum of Understanding (MOU). On March 26, 2013, a follow-up meeting was held. The Directors of Metro and Napa hospitals participated, which allowed for discussion regarding services provided. DSH requested the usage of a bed pool containing approximately 500 beds per month. DSH and CMHDA will be working collaboratively on legislative changes needed. DSH stated they will base their rates on actual usage of hospital beds starting in 2014 – 2015. A mutual negotiation of a joint contract occurred with positive results. The next meeting will take place on April 24, 2013.

Mr. Chaquica presented the costs thus far for planning and development of the state hospital bed program. The costs will be reviewed by the CalMHSA Finance Committee on its next call. He then asked for direction on moving forward with development.

Recommendation: ***Discussion and/or action as deemed appropriate.***

Public comment was heard from the following individual(s):
None

Following Mr. Chaquica's presentation, Ms. Li informed President Clark that a quorum of the Board had been reached. President Clark then proceeded with the Board of Directors meeting.

9. ADMINISTRATIVE MATTERS

A. JPA Agreement Amendment Update

Mr. Chaquica, Executive Director, communicated particulars concerning the JPA Agreement Amendment, indicating that it would be able to advance funds. Donnell Ewert, Shasta County, inquired whether this document was vetted through the County Counsels' Association. Mr. Alliston responded stating that it was not. Mr. Chaquica encouraged members to share with their county counsels. As the discussion continued, Ms. Bauman noted there were no significant changes other than including projects without MHSA funds. Madelyn Schlaepfer, Stanislaus County, stated that her county counsel has identified about 10 counties having issues with the amendment. Barbara LaHaie, Humboldt County, made known Humboldt County had in fact reviewed the document and counsel has issues, therefore, they would not support approving the amendment. Mr. Chaquica explained if this did not get completed by July 1, 2013, then they would not be able to move successfully forward with the Department of State Hospitals.

Action: ***Ratify the Executive Committee's approval of the CalMHSA JPA Agreement as presented on February 15, 2013, with an effective date of July 1, 2013, to allow time for members' Boards of Supervisors to approve.***

Motion: ***Alfredo Aguirre, San Diego County***
Second: ***William Arroyo, Los Angeles County***

Opposed: ***Barbara LaHaie, Humboldt County***

Public comment was heard from the following individual(s):
None

B. Nominating Committee Approval

Mr. Douglas confirmed selecting Wayne Clark, Karen Baylor, and Anne Robin for the nominating committee.

Action: ***Approval of Nominating Committee for the 2013 Executive Committee Election, to be held at the June 13, 2013 Board of Directors Meeting.***

Motion: ***Maureen F. Bauman, Placer County***
Second: ***Noel O'Neill, Trinity County***

Motion passed unanimously.

Public comment was heard from the following individual(s):
None

10. GENERAL DISCUSSION

A. Report from CalMHSA President – Wayne Clark

President Clark allowed Scott Gruendl, Glenn County, CalMHSA Treasurer, to briefly comment on the Finance Committee. Mr. Gruendl explained how the Finance Committee has created a sub-committee to review the George Hills Company contract related to its expiration date.

Recommendation: Discussion and/or action as deemed appropriate.

Public comment was heard from the following individual(s):
None

B. Report from CalMHSA Executive Director – John Chaquica

Mr. Chaquica reported CalMHSA has received preliminary approval for the extension of the contract with the Department of Health Care Services. This agreement has not been finalized nor have any of the proposed changes been made. A follow up meeting will be scheduled to take further action.

Recommendation: None, information only.

Public comment was heard from the following individual(s):
None

STRATEGIC PLANNING DISCUSSION

President Clark invited Ms. Bauman, Ms. Robin, and Ms. Collentine to present on the first recommendation.

Recommendation #1- Renew commitment to statewide PEI

Ms. Collentine discussed CalMHSA's current statewide PEI projects. Ms. Bauman shared a proposed process and methodology for determining which initiatives to pursue and how to fund them, then discussed a strategic planning framework for PEI projects.

The full Board discussed the extent of time for which the planning would be complete and specifics pertaining to the funding for the strategic planning process. Following the discussion concerning strategic planning, the Board discussed the PEI process and the different levels of funding needed for sustainability.

President Clark invited Mr. Gruendl, Mr. Rawland, and Mr. Chaquica to present on the second recommendation.

Recommendation #2 – A mechanism and process for counties to fund projects jointly

Mr. Gruendl explained that the primary focus for Recommendation #2 was on the funding side and explained that a new funding process needed to be figured out. The

Board then discussed differences between the agreement between the counties and the MOU and deliberated about the meaning of “approval by the Mental Health Board.” Further discussion among the Board members revealed there were minor discrepancies in the wording of this recommendation and editing would be needed for both the recommendation as well as the description.

President Clark invited Dr. William Arroyo, Los Angeles County, and Mr. Chaquica to present on the third recommendation.

Recommendation #3 – Approve methodologies for the selection of additional projects for counties to act jointly

Dr. Arroyo discussed additional projects beyond the three statewide PEI projects. The Board would later agree on an approval process for specific projects.

A group vote was conducted on the potential projects:

Project Name	Yes	No	Maybe
State Hospital Beds	16	0	3
Suicide Prevention Program	15	2	4
Getting grant funding (e.g., SAMHSA)	14	1	5
Workforce Education Training (WET)	12	7	0
Database Management	11	1	8
Litigation Pool Management	8	1	12
MHSA Housing Program	7	10	3
Communication Program	6	4	10
EPSDT	6	11	3
Collective Addressing IT Program Changes	5	3	11
Procurement of Services	5	8	7
Individual and Collective Mental Health Projects	4	4	10
Drug-Medical (Development of regional approaches)	4	9	7
Fiscal Risk Pools	4	10	4
AB 109 (Glenn County)	3	12	3
Affordable Care Act	2	2	17
Health Benefit Exchange	2	9	10

Assurance of Statewide Reach Programs	1	11	7

Public comment was heard from the following individual(s):
None

Mr. Douglas than turned the floor back to President Clark to commence a vote on each recommendation presented.

Action: ***Recommendation #1—Renew our commitment to statewide PEI.***

Motion: ***Maureen Bauman, Placer County***
Second: ***Anne Robin, Butte County***

Motion passed unanimously.

Public comment was heard from the following individual(s):
None

Action: ***Recommendation #2—Approval of a general funding process for counties to act jointly.***

Motion: ***Noel O'Neill, Trinity County***
Second: ***Jay Vanderhurst, Napa County***

Motion passed unanimously.

Public comment was heard from the following individual(s):
None

Action: ***Recommendation #3—Approval of methodologies to select additional projects for counties to act jointly.***

Dr. Arroyo explained the vote was for the concept, not the detailed language currently included in the recommendation. Mr. Douglas clarified the Board intends the chart to be part of the motion.

Motion: ***William Arroyo, Los Angeles County***
Second: ***Anne Robin, Butte County***

Motion passed unanimously.

Public comment was heard from the following individual(s):
None

President Clark then asked for a motion to approve the four validation statements:

1. CalMHSA should reaffirm counties' desire to work together for fiscal and administrative reasons to achieve overall efficiencies.
2. CalMHSA should sustain certain MHSA Statewide Prevention and Early Intervention (PEI) Initiatives.
3. CalMHSA should expand into other non-MHSA (non-PEI) Initiatives, as well as other non-MHSA projects (e.g., State Hospital Beds).
4. CalMHSA should be available to assist in the following fiscal and administrative capacity:
   a. Statewide
   b. Regional
   c. Local

Action: ***Approval of the four validation statements presented.***

Motion: ***Karen Stockton, Modoc County***
Second: ***Brad Luz, Sutter/Yuba County***

Motion passed unanimously.

Public comment was heard from the following individual(s):
None

11. PUBLIC COMMENTS

A. Public Comments – Non-Agenda Items

President Clark invited members of the public to make comments on non-agenda items.

Public comment was heard from the following individual(s):
None

12. NEW BUSINESS AND CLOSING COMMENTS

President Clark asked the board if there was any new business or closing comments. Hearing none, he entertained a motion to adjourn.

13. ADJOURNMENT

There being no further comments, the meeting was adjourned at 1:57 p.m.

Action: ***To adjourn meeting.***

Motion: ***Noel O'Neill, Trinity County***
Second: ***William Arroyo, Los Angeles County***

Motion carried unanimously.

Respectfully submitted,

_______________________________ _______________
Karen Baylor, PhD, LMFT Date
Secretary, CalMHSA

2013 STRATEGIC PLANNING SESSION

RECOMMENDATION 1: Renew Commitment to Statewide PEI.

Strategies	Target Completion Date	Status
1.1.1	12/2013	Committee forming

RECOMMENDATION 2: A mechanism and process for counties to fund projects jointly.

Strategies	Target Completion Date	Status
2.1.1	6/13/13	To be discussed with budget

RECOMMENDATION 3: Approve methodologies in selection of additional projects for counties to act jointly.

Strategies	Target Completion Date	Status
3.1.1	8/2013	Refinement of project to be discussed

2012 STRATEGIC PLANNING SESSION

GOAL 1: Provide Effective Services to Member Counties

Objectives	Strategies	Target Completion Date	Status
1.1 Complete the three statewide PEI projects	1.1.1 Continue to implement the funded statewide PEI projects.	6/30/14	In process
	1.1.2 Develop a sustainability plan for those projects that prove successful.	6/30/14	To present at the April 2013 SPS
1.2 Provide additional services in fiscal and administrative management	1.2.1 Prepare analysis of the capacity CalMHSA needs to implement objectives (e.g., staff, other resources) for Executive Committee and determine options and pricing.	Unknown	On hold until objectives determined
	1.2.2 Serve as fiscal agent for the counties' EPSDT funds.	*n/a*	*CalMHSA not eligible*
	1.2.3 Serve as fiscal agent and project manager for local PEI funds (at risk of reversion).	5/9/2012	Position research paper completed
	1.2.4 Upon direction of CMHDA, negotiate contracts with the state (e.g., to manage state hospital beds).	6/30/13	Joint MOU with state in development, operational plans on hold until finished
	1.2.5 Serve as fiscal and administrative agent for procurement of services (e.g., legal, public relations, facilitation, fiscal, economic or financial expertise). • Work with Executive Committee to draft language that counties could use with their Board of Supervisors to create the mechanism that enables them to use these services (amend JPA agreement).	On-going	Proposed changes to JPA Agreement (December 2012) February 15, 2013
	1.2.6 On a case-by-case basis, procure services for counties in order to achieve economies of scale (e.g., to purchase residential services for adolescents or to manage risk).		
	a. Prepare list of regional needs and ideas, send to CalMHSA Executive Committee	8/2012	Not started
	b. Discuss topic of electronic medical records with Scott Gruendl	*New software vendor being utilized alleviating the need*	

2012 STRATEGIC PLANNING SESSION

GOAL 1: Provide Effective Services to Member Counties

Objectives	Strategies	Target Completion Date	Status
	c. Meet with Small Counties Group to vet possibilities.	6/2012	Meeting on June 26, 2013 re locum tenens
	1.2.7 Assist in the fiscal management of AB100 and 2011 realignment county mental health revenues and risk pools.	Unknown	On hold pending further direction
	1.2.8 At the request of counties, hold and manage contracts with the state.	n/a	None requested
	1.2.9 Offer fiscal and administrative support to counties and associations (e.g., CADPAAC).	Unknown	On hold pending further direction
	1.2.10 On behalf of counties, apply for state or federal grants.	Unknown	None requested
1.3 Assure effective communication and public relations	1.3.1 Develop public information resources for county mental health departments and CMHDA.	In process	First product PEI brochure in print
	1.3.2 In collaboration with county and CMHDA staff, develop and implement a short and long term public communication and information program that educates and informs the public and other stakeholders regarding the role of counties in the community mental health system.	6/2014	In process

GOAL 2: Assure Accountability to Counties

Objectives	Strategies	Target Completion Date	Status
2.1 Assure project tracking systems are in place	2.1.1 Continual use of CalMatrix for project tracking and reporting.	n/a	On-going
2.2 Assure governance systems are effective	2.2.1 Conduct CalMHSA Evaluation of Performance (governance, administration, fiscal, program, etc.).	n/a	Finance Committee - GHC
2.3 Assure fiscal systems are in place	2.3.1 Regularly report to Finance Committee.	n/a	On-going
2.4 Assure staff receive appropriate training and development	2.4.1 Staff to assess and develop a training plan.	n/a	On-going

"A George Hills Company Administered JPA"

Treasurer's Report

As of December 31, 2012

	Book Balance	Market Value	Effective Yield
Local Agency Investment Fund	$22,178,025	$22,203,025	.326%
Morgan Stanley Smith Barney	91,102,268	91,300,182	1.89%
Cash with California Bank & Trust	86,385	86,385	0.00%
Total Cash and Investments	**$113,366,678**	**$113,589,592**	

Attached are the Local Agency Investment Fund (LAIF) statements detailing all investment transactions.

The LAIF market value was derived by applying the March fair value factor of 1.001127231 to the book balance.

I certify that this report reflects all cash and investments and is in conformance with the Authority's Investment Policy. The investment program herein shown provides sufficient cash flow liquidity to meet the Authority's expenditures for the next six (6) months.

Respectfully submitted,

Kim Santin, Finance Director

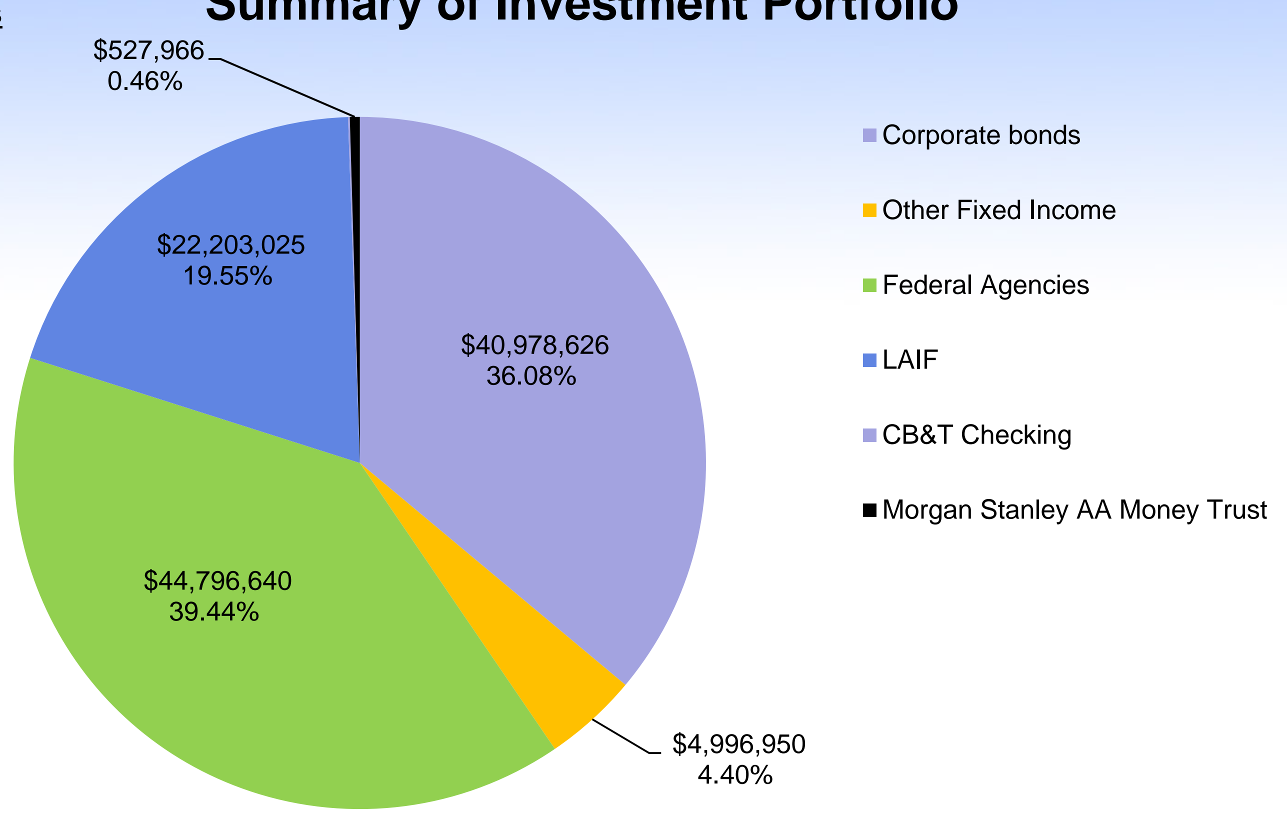
Accepted,

Scott Gruendl, Treasurer

Total Cash Portfolio Dollars – December 31, 2012

Investment Policy Objectives

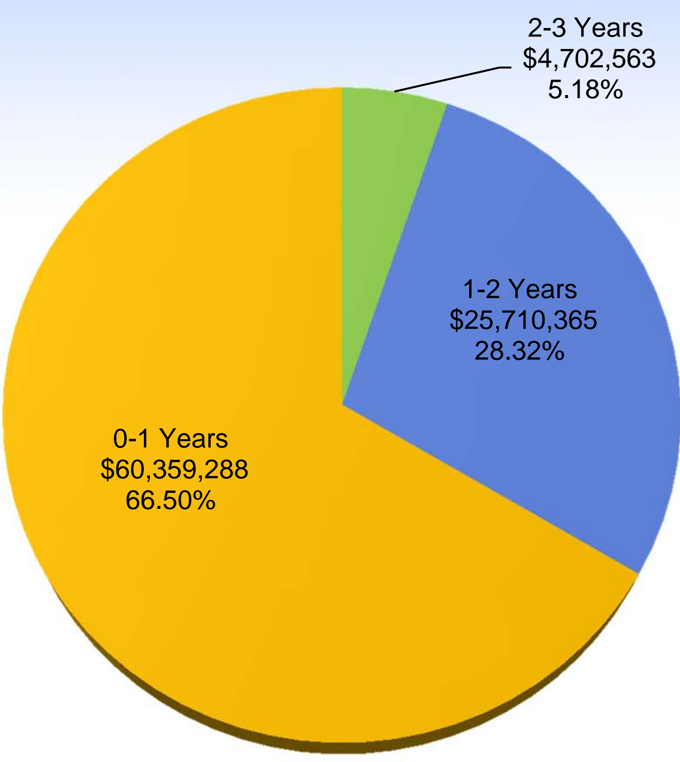
- Safety of Principal
- Meeting Liquidity Needs
- Rate of Return



Total Cash and Investments $113,589,592

Compassion. Action. Change.

Total Cash Portfolio Dollars – December 31, 2012



Total Investments $90,772,216

Compassion. Action. Change.

CALMHSA'S QUARTERLY TREASURER'S REPORT
AS OF DECEMBER 31, 2012

INVESTMENTS	Date of Purchase	Date of Maturity	Par Value	Adjusted Cost	Market Value	YTM (at Cost)	YTM (at Market)	YTD Unrealized Gains/(Losses)
Corporate Bonds:								
Westpac Bking Corp NY	1/20/2012	1/22/2013	5,000,000	5,000,000	5,001,900	0.73%	0.73%	1,900
Standard Chartered Bk New York	10/22/2012	3/19/2013	5,000,000	5,000,000	5,002,900	0.47%	0.47%	2,900
Wacovia Corp	10/11/2012	8/1/2013	5,000,000	5,154,970	5,155,850	5.53%	5.53%	880
PepsiCo Inc/NC	1/20/2012	10/25/2013	4,950,000	4,967,172	4,972,671	0.87%	0.87%	5,499
Westpac Bking Corp NY	12/3/2012	12/3/2013	5,000,000	5,000,000	4,999,050	0.38%	0.38%	(950)
General Electric Capital Corp	1/20/2012	1/7/2014	2,945,000	2,970,616	2,993,327	2.08%	2.07%	22,711
John Deere Capital Corp	1/20/2012	3/3/2014	2,275,000	2,299,415	2,304,848	1.58%	1.58%	5,433
Bank of New York Mellon	1/20/2012	5/15/2014	2,760,000	2,887,644	2,900,677	4.11%	4.09%	13,033
JPMorgan Chase & Co	1/20/2012	6/1/2014	2,795,000	2,906,402	2,944,840	4.47%	4.41%	38,438
Coca-Cola Co	12/13/2012	3/13/2015	4,667,000	4,692,485	4,702,563	0.75%	0.74%	10,078
Total corporate bonds			40,392,000	40,878,704	40,978,626	1.93%	1.93%	99,922
Other Fixed Income:								
Toyota Motor Credit Co	7/19/2012	4/15/2013	5,000,000	4,982,440	4,996,950	N/A	N/A	14,510
Federal Agencies								
FHLB Notes .5%	1/20/2012	8/28/2013	4,970,000	4,976,666	4,980,437	0.50%	0.50%	3,771
FHLB Notes 3.875%	1/20/2012	6/14/2013	4,740,000	4,818,092	4,819,774	3.81%	3.81%	1,682
FHLMC Notes 4.5%	1/20/2012	7/15/2013	4,700,000	4,807,532	4,810,215	4.40%	4.40%	2,683
FHLMC 5%	1/20/2012	7/15/2014	2,695,000	2,881,144	2,890,980	4.68%	4.66%	9,836
FNMA .5%	1/20/2012	8/9/2013	4,970,000	4,976,224	4,979,592	0.50%	0.50%	3,368
FNMA DEBS 4.125%	1/20/2012	4/15/2014	2,740,000	2,869,664	2,877,329	3.94%	3.93%	7,665
FHLMC 1%	1/20/2012	7/30/2014	2,940,000	2,963,421	2,975,280	0.99%	0.99%	11,859
FHLMC .375%	1/20/2012	10/30/2013	4,990,000	4,991,032	4,997,635	0.37%	0.37%	6,603
FNMA 2.75%	1/20/2012	2/5/2014	2,825,000	2,896,663	2,905,908	2.68%	2.67%	9,245
FNMA MED 2.75%	6/6/2012	12/18/2013	650,000	652,705	653,744	0.75%	0.75%	1,039
FNMA 3%	1/20/2012	9/16/2014	2,785,000	2,901,467	2,917,176	2.88%	2.86%	15,709
FNMA .75%	1/20/2012	12/18/2013	4,960,000	4,978,548	4,988,570	0.75%	0.75%	10,022
Total government & GSE bonds			43,965,000	44,713,158	44,796,640	2.11%	2.11%	83,482
Total Portfolio Investments			89,357,000	90,574,302	90,772,216			197,914
Local Agency Investment Fund (LAIF)			-	22,178,025	22,203,025			-
Morgan Stanley AA Money Trust			-	527,966	527,966			-
Checking Account			-	86,385	86,385			-
Total Cash and Investments			89,357,000	113,366,678	113,589,592			197,914

*Government Sponsored Entity

Summary of Portfolio Investments		Year to Date Activity of	
Corporate Bonds	40,978,626	Fair Market Value 7/1/12	90,699,394
Other Fixed Income	4,996,950	Purchases	34,280,080
Federal Agencies	44,796,640	Sales/Maturities	(33,799,924)
		Net Unrealized Gains(Losses)	(407,334)
	90,772,216		
		Fair Market Value 12/31/12	90,772,216

2-3 year	$ 4,702,563
1-2 year	25,710,365
0-1 year	60,359,288
	$ 90,772,216

NOTES:

Market Value is an approximation of the total worth of the asset, and fluctuates on a daily basis depending on market factors.
YTM at Cost is the constant interest rate that makes the net present value of future principals & interest cash flows equal the purchase price of the security on the acquisition date.
YTM at Market is the constant interest rate that makes the net present value of future principal & interest cash flows equal the current market price of the security.
Market values and Yields are from the following sources: Morgan Stanley Smith Barney Financial Management Account Summaries; all investments are in compliance with CalMHSA's current investment policy. CalMHSA has sufficient funds to meet its expenditure requirements for the next six months.

Prepared by ______________________
Treasurer

"A George Hills Company Administered JPA"

Treasurer's Report

As of March 31, 2013

	Book Balance	Market Value	Effective Yield
Local Agency Investment Fund	$23,699,317	$23,723,457	.326%
Morgan Stanley Smith Barney	81,316,477	81,471,189	1.89%
Cash with California Bank & Trust	73,851	73,851	0.00%
Total Cash and Investments	**$105,089,645**	**$105,268,497**	

Attached are the Local Agency Investment Fund (LAIF) statements detailing all investment transactions.

The LAIF market value was derived by applying the March fair value factor of 1.0010186 to the book balance.

I certify that this report reflects all cash and investments and is in conformance with the Authority's Investment Policy. The investment program herein shown provides sufficient cash flow liquidity to meet the Authority's expenditures for the next six (6) months.

Respectfully submitted,

Kim Santin, Finance Director

Accepted,

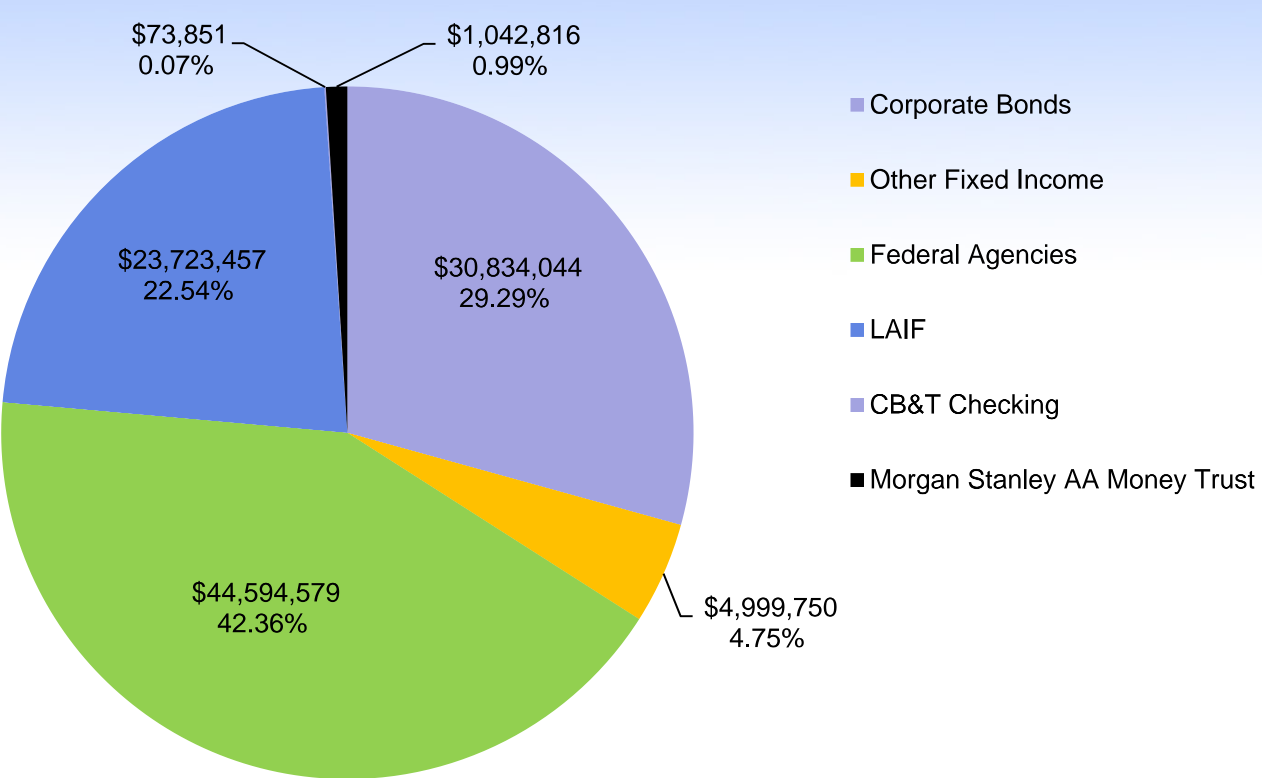
4/25/13

Scott Gruendl, Treasurer

Total Cash Portfolio Dollars – March 31, 2013

<u>Investment Policy Objectives</u>

- Safety of Principal
- Meeting Liquidity Needs
- Rate of Return

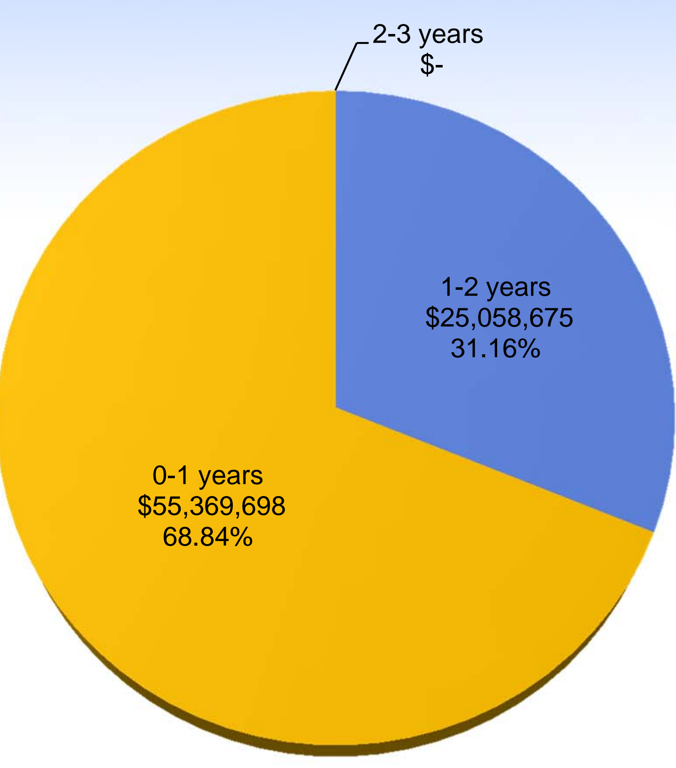


Total Cash and Investments $105,268,497

Compassion. Action. Change.

Total Cash Portfolio Dollars – March 31, 2013

Summary of Maturities



Total Investments $80,428,373

Compassion. Action. Change.

CALMHSA'S QUARTERLY TREASURER'S REPORT
AS OF MARCH 31, 2013

INVESTMENTS	Date of Purchase	Date of Maturity	Par Value	Adjusted Cost	Market Value	YTM (at Cost)	YTM (at Market)	YTD Unrealized Gains/(Losses)
Corporate Bonds:								
Wacovia Corp	10/11/2012	8/1/2013	5,000,000	5,088,568	5,088,050	5.60%	5.60%	(518)
PepsiCo Inc/NC	1/20/2012	10/25/2013	4,950,000	4,961,923	4,964,652	0.87%	0.87%	2,729
Westpac Bking Corp NY	12/3/2012	12/3/2013	5,000,000	5,000,000	5,005,200	0.38%	0.38%	5,200
General Electric Capital Corp	3/14/2013	9/15/2014	2,820,000	2,988,484	2,984,209	4.48%	4.49%	(4,275)
John Deere Capital Corp	1/20/2012	3/3/2014	2,275,000	2,294,225	2,300,958	1.59%	1.58%	6,733
Bank of New York Mellon	1/20/2012	5/15/2014	2,760,000	2,864,502	2,879,287	4.14%	4.12%	14,785
JPMorgan Chase & Co	1/20/2012	6/1/2014	2,795,000	2,886,928	2,920,887	4.50%	4.45%	33,959
Coca-Cola Co	12/13/2012	3/13/2015	4,667,000	4,689,602	4,690,802	0.75%	0.75%	1,200
Total corporate bonds			30,267,000	30,774,232	30,834,044	2.60%	2.60%	59,813
Other Fixed Income:								
Toyota Motor Credit Co	7/19/2012	4/15/2013	5,000,000	4,982,440	4,999,750	N/A	N/A	17,310
Federal Agencies								
FHLB Notes .5%	1/20/2012	8/28/2013	4,970,000	4,974,136	4,977,604	0.50%	0.50%	3,468
FHLB Notes 3.875%	1/20/2012	6/14/2013	4,740,000	4,774,973	4,776,972	3.85%	3.85%	1,999
FHLMC Notes 4.5%	1/20/2012	7/15/2013	4,700,000	4,757,651	4,761,006	4.45%	4.44%	3,355
FHLMC 5%	1/20/2012	7/15/2014	2,695,000	2,850,985	2,861,201	4.73%	4.71%	10,215
FNMA .5%	1/20/2012	8/9/2013	4,970,000	4,973,655	4,976,610	0.50%	0.50%	2,955
FNMA DEBS 4.125%	1/20/2012	4/15/2014	2,740,000	2,844,578	2,852,230	3.97%	3.96%	7,653
FHLMC 1%	1/20/2012	7/30/2014	2,940,000	2,959,728	2,970,958	0.99%	0.99%	11,231
FHLMC .375%	1/20/2012	10/30/2013	4,990,000	4,990,722	4,995,988	0.37%	0.37%	5,266
FNMA 2.75%	1/20/2012	2/5/2014	2,825,000	2,880,319	2,888,337	2.70%	2.69%	8,017
FNMA MED 2.75%	6/6/2012	12/18/2013	650,000	652,004	652,847	0.75%	0.75%	843
FNMA 3%	1/20/2012	9/16/2014	2,785,000	2,884,496	2,899,101	2.90%	2.88%	14,605
FNMA .75%	1/20/2012	12/18/2013	4,960,000	4,973,742	4,981,725	0.75%	0.75%	7,983
Total government & GSE bonds			43,965,000	44,516,989	44,594,579	2.12%	2.12%	77,590
Total Portfolio Investments			79,232,000	80,273,661	80,428,373			154,712
Local Agency Investment Fund (LAIF)			-	23,699,317	23,723,457			-
Morgan Stanley AA Money Trust			-	1,042,816	1,042,816			-
Checking Account			-	73,851	73,851			-
Total Cash and Investments			79,232,000	105,089,645	105,268,497			154,712

*Government Sponsored Entity

Summary of Portfolio Investments	
Corporate Bonds	30,834,044
Other Fixed Income	4,999,750
Federal Agencies	44,594,579
	80,428,373
2-3 year	$ -
1-2 year	25,058,675
0-1 year	55,369,698
	$ 80,428,373

Year to Date Activity of	
Fair Market Value 7/1/12	90,699,394
Purchases	37,272,410
Sales/Maturities	(46,787,038)
Net Unrealized Gains(Losses)	(756,393)
Fair Market Value 2/28/13	80,428,373

NOTES:

Market Value is an approximation of the total worth of the asset, and fluctuates on a daily basis depending on market factors.
YTM at Cost is the constant interest rate that makes the net present value of future principals & interest cash flows equal the purchase price of the security on the acquisition date.
YTM at Market is the constant interest rate that makes the net present value of future principal & interest cash flows equal the current market price of the security.
Market values and Yields are from the following sources: Morgan Stanley Smith Barney Financial Management Account Summaries; all investments are in compliance with CalMHSA's current investment policy. CalMHSA has sufficient funds to meet its expenditure requirements for the next six months.

California Mental Health Services Authority
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SUMMARY OF SIGNIFICANT CHANGES IN FINANCIAL STATEMENTS
FOR THE SIX MONTHS ENDING
DECEMBER 31, 2012

BALANCE SHEET:

Cash and cash equivalents - Overall cash balance is $22.8 million as of December 31, 2012. This is a decrease of $16.6 million compared to the $39.4 million in cash as of June 30, 2012. The decrease in cash mainly relates to the expenditures for the PEI and TTACB programs.

Investments – Current Portion – See Treasurers' Report

Contractor prepayments – The overall prepaid balance is $2.3 million as of December 31, 2012. The balance has decreased by $1.0 million compared to the balance as of June 30, 2012 as the contractors begin to draw down on their initial deposits. CalMHSA has instructed the program partners to draw down their prepayments by June 30, 2013.

TTACB receivables - $436,311 in TTACB receivables are due from the following counties:

• Placer	$21,000
• Solano	$61,200
• Inyo	$2,100
• Lake	$8,900
• Los Angeles	$300,000
• Marin	$10,711
• Modoc	$1,200
• Yolo	$31,200
• Total	$436,311

Program and planning receivables – $75,000 in total planning and program receivables are due from Mariposa County. Mariposa Country will be invoiced for the remaining funds on or about July 1, 2013.

Interest receivable – Total interest receivable of $511,029 includes $21,292 in accrued LAIF interest and $489,737 in accrued bond interest.

Noncurrent Investments – See Treasurers' Report

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Accounts Payable – The balance in account payable as of December 31, 2012 is $5.5 million. The vendors with the most significant balances are:

• AdEase	$796,276
• CCSESA	$508,960
• California State University	$276,996
• California Institute for Mental Health	$81,186
• Didi Hirsch	$270,773
• Entertainment Industries Council	$222,223
• Foundation for California Community Colleges	$339,061
• Institute on Aging	$79,248
• LivingWorks Education	$103,540
• Mental Health Association in California	$140,179
• Mental Health Association of San Francisco	$144,364
• Mental Health Consumer Concerns	$94,551
• National Alliance on Mental Health Illness	$133,264
• Rand Corporation	$779,136
• The Regents of the University of California	$390,468
• Runyon Saltzman & Einhorn	$484,725
• San Francisco Suicide Prevention	$112,658
• United Advocates for Children and Families	$119,475
• Total	$5,077,083

STATEMENT OF REVENUE AND CHANGES IN NET ASSETS:

Operating Revenue –Total revenue for the six months ended December 31, 2012 was $436,311. This relates to the fiscal year 2012/2013 billing for TTACB.

Expenses – Overall expenses for the six months ended, December 31, 2012 were approximately $18.3 million. The expenses mainly related to planning and program costs for implementation of the state-wide program initiatives.

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

UNAUDITED

BALANCE SHEET

	December 31, 2012	June 30, 2012
ASSETS		
Current Assets:		
Cash & Cash Equivalents	$ 22,817,376	$ 39,436,531
Investments - Current Portion	60,359,288	29,399,596
Contractor Prepayments	2,323,771	3,369,932
Receivables:		
Tech Asst/Capacity Building	436,311	119,400
PEI Program Funds	71,250	285,000
PEI Planning Funds	3,750	15,000
Application Fees	1,250	1,500
Interest	511,029	394,593
Total Current Assets	86,524,025	73,021,552
Noncurrent Assets:		
Investments	30,412,928	61,299,798
Total Assets	$ 116,936,953	$ 134,321,350
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Accounts Payable and Accrued Expenses	$ 5,525,775	$ 5,445,801
WET Program Funding	155,220	155,220
Total Current Liabilities	5,680,995	5,601,021
Net Assets:		
Operations	536,188	318,063
Tech Asst/Capacity Building	402,647	48
PEI Program Funding	110,317,123	128,402,218
Total Net Assets	111,255,958	128,720,329
Total Liabilities and Net Assets	$ 116,936,953	$ 134,321,350

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

UNAUDITED
STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

For the Six Months Ended, December 31, 2012 and December 31, 2011

	Operations	Tech Asst/ Capacity Building	PEI Program Funding	2012 Total	2011 Total
OPERATING REVENUES:					
Technical Assistance/Capacity Building	$ -	$ 436,311	$ -	$ 436,311	$ -
Community Planning (5%)	-	-	-	-	1,918,805
PEI State Wide Program Funding	-	-	-	-	36,457,295
Application Fee	-	-	-	-	12,249
Total Operating Revenue	-	436,311	-	436,311	38,388,349
PROGRAM EXPENSES:					
Technical Assistance/Capacity Building					
Program Contract	-	21,591	-	21,591	17,926
Program Implementation & Oversight	-	20,725	-	20,725	-
PEI State Wide Program Funding:					
Program Expense:					
Program Contract	-	-	16,022,508	16,022,508	1,751,029
Program Mgmt. & Oversight	-	-	544,709	544,709	-
Legal	-	-	3,090	3,090	30,729
Meeting and Other	-	-	12,901	12,901	-
Evaluation Expense:				-	
Program Contract	-	-	756,461	756,461	-
Program Mgmt. & Oversight	-	-	28,174	28,174	-
Meeting and Other	-	-	3,356	3,356	-
Planning Expense:					
Program Mgmt. & Oversight	-	-	65,740	65,740	894,108
Other Contract Services	-	-	13,650	13,650	114,815
Legal	-	-	-	-	70,998
Marketing	-	-	92,957	92,957	
Meeting and Other	-	-	644	644	76,505
Total Program Expense	-	42,316	17,544,190	17,586,506	2,956,110
INDIRECT EXPENSES:					
General Management	44,240	1,091	300,529	345,860	-
Other Contract Services	5,256	-	21,550	26,806	-
Legal Services	25,382	-	25,715	51,097	-
Insurance	-	-	32,374	32,374	29,938
Investment Management Fees	66,557	-	-	66,557	-
Marketing	-	-	29,400	29,400	-
Meeting and Other	21	-	65,017	65,038	12,499
Formation Fees	-	-	56,625	56,625	-
Total General And Administrative	141,456	1,091	531,210	673,757	42,437
Total Expenses	141,456	43,407	18,075,400	18,260,263	2,998,547
(Loss) Income from Operations	(141,456)	392,904	(18,075,400)	(17,823,952)	35,389,802
FORMATION FEE ALLOCATION	-	9,695	(9,695)	-	-
NONOPERATING INCOME:					
Investment Income	789,318	-	-	789,318	98,614
Change in Investment Value	(429,737)	-	-	(429,737)	(4,610)
Total Nonoperating Income	359,581	-	-	359,581	94,004
Change in Net Assets	218,125	402,599	(18,085,095)	(17,464,371)	35,483,806
Beginning Net Assets	318,063	48	128,402,218	128,720,329	104,608,021
Ending Net Assets	$ 536,188	$ 402,647	$ 110,317,123	$ 111,255,958	$ 140,091,827

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

UNAUDITED
STATEMENT OF CASH FLOWS

For the Six Months Ended, December 31, 2012 and December 31, 2011

	2012	2011
Cash Flows from Operating Activities:		
Cash Payments for Technical Assistant/Capacity Building	$ (465,500)	$ -
Cash Payments for PEI State Wide Program Funding	(15,583,174)	(5,134,466)
Cash Payments for Planning Expense	(161,964)	(1,185,387)
Cash Payments for Evaluation Expense	(304,772)	-
Cash Payments for Indirect Expenses	(504,151)	(29,938)
Cash Payments for General & Administrative Expenses	(114,567)	-
Cash Payments Received for PEI Community Planning	11,250	2,553,350
Cash Payments Received for Program Funding	213,750	48,513,650
Cash Payments Received for Technical Assistant/Capacity Building	119,400	-
Cash Received for Application Fees	250	1,000
Net Cash (Used) Provided by Operating Activities	(16,789,478)	44,718,209
Cash Flows from Investing Activities:		
Cash Received for Investment Income	718,299	66,912
Cash Received for Investment Maturity	33,799,924	-
Cash Payments for Purchases of Investments	(34,347,900)	-
Net Cash Provided by Investing Activities	170,323	66,912
Net Change in Cash and Cash Equivalents	(16,619,155)	44,785,121
Beginning Cash and Cash Equivalents	39,436,531	91,445,563
Ending Cash and Cash Equivalents	$ 22,817,376	$ 136,230,684

Reconciliation of Operating Income to Net Cash Provided by Operating Activities:	2012	2011
Operating (Loss) Income:	$ (17,823,952)	$ 35,389,802
Adjustment to net cash used by operating activities:		
(Increase) Decrease in Accounts Receivable	(91,661)	12,692,150
Decrease (Increase) in Contractor Prepayments	1,046,161	(4,054,576)
Increase in Accounts Payable	79,974	690,833
Net Cash (Used) Provided By Operating Activities	$ (16,789,478)	$ 44,718,209

Supplementary Information

Noncash Financing and Investing Activities:	2012	2011
Decrease in Fair Market Value of Investment	(429,737)	(4,610)

California Mental Health Services Authority
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SUMMARY OF SIGNIFICANT CHANGES IN FINANCIAL STATEMENTS FOR THE NINE MONTHS ENDING MARCH 31, 2013

BALANCE SHEET:

Cash and cash equivalents **-** Overall cash balance is $24.8 million as of March 31, 2013. This is a decrease of $14.6 million compared to the $39.4 million in cash as of June 30, 2012. The decrease in cash relates to the $25.3 million of net cash used for the PEI and TTACB programs offset by $10.7 million of net cash received from investment maturities and investment earnings.

Investments – Current Portion – See Treasurers' Report

Contractor prepayments – The overall prepaid balance is $2.0 million as of March 31, 2013. The balance has decreased by $1.4 million compared to the balance as of June 30, 2012 as the contractors begin to draw down on their initial deposits. CalMHSA has instructed the program partners to draw down their prepayments by June 30, 2013.

TTACB receivables - $463,411 in TTACB receivables are due from the following counties:

• Placer	$21,000
• Solano	$61,200
• Inyo	$2,100
• Los Angeles	$300,000
• Marin	$10,711
• Monterey	$68,400
• Total	$463,411

Program and planning receivables – $75,000 in total planning and program receivables are due from Mariposa County. Mariposa Country will be invoiced for the remaining funds on or about July 1, 2013.

Interest receivable – Total interest receivable of $411,230 includes $14,274 in accrued LAIF interest and $396,956 in accrued bond interest.

Noncurrent Investments – See Treasurers' Report

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Accounts Payable – The balance in account payable as of March 31, 2013 is $1.7 million. The vendors with the most significant balances are:

• California State University	$285,945
• Didi Hirsch	$103,695
• Disability Rights California	$77,014
• Foundation for California Community Colleges	$188,109
• Mental Health Association in California	$152,450
• Mental Health Association of San Francisco	$204,185
• Rand Corporation	$226,165
• The Regents of the University of California	$191,902
• Total	$1,429,465

STATEMENT OF REVENUE AND CHANGES IN NET ASSETS:

Operating Revenue –Total revenue for the nine months ended March 31, 2013 was $504,711. This relates to the fiscal year 2012/2013 billing for TTACB.

Expenses – Overall expenses for the nine months ended, March 31, 2013 were approximately $23.3 million. The expenses mainly related to planning and program costs for implementation of the state-wide program initiatives.

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

UNAUDITED
BALANCE SHEET

	March 31, 2013	June 30, 2012
ASSETS		
Current Assets:		
Cash & Cash Equivalents	$ 24,840,124	$ 39,436,531
Investments - Current Portion	55,369,698	29,399,596
Contractor Prepayments	2,013,109	3,369,932
Receivables:		
Tech Asst/Capacity Building	463,411	119,400
PEI Program Funds	71,250	285,000
PEI Planning Funds	3,750	15,000
Application Fees	1,250	1,500
Interest	411,230	394,593
Total Current Assets	83,173,822	73,021,552
Noncurrent Assets:		
Investments	25,058,675	61,299,798
Total Assets	$ 108,232,497	$ 134,321,350
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Accounts Payable and Accrued Expenses	$ 1,684,915	$ 5,445,801
WET Program Funding	155,220	155,220
Total Current Liabilities	1,840,135	5,601,021
Net Assets:		
Operations	623,893	318,063
Tech Asst/Capacity Building	467,386	48
PEI Program Funding	105,301,083	128,402,218
Total Net Assets	106,392,362	128,720,329
Total Liabilities and Net Assets	$ 108,232,497	$ 134,321,350

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

UNAUDITED
STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

For the Nine Months Ended, March 31, 2013 and March 31, 2012

	Operations	Tech Asst/ Capacity Building	PEI Program Funding	2013 Total	2012 Total
OPERATING REVENUES:					
Technical Assistance/Capacity Building	$ -	$ 504,711	$ -	$ 504,711	$ -
Community Planning (5%)	-	-	-	-	1,902,665
PEI State Wide Program Funding	-	-	-	-	36,150,635
Application Fee	-	-	-	-	14,249
Total Operating Revenue	-	504,711	-	504,711	38,067,549
PROGRAM EXPENSES:					
Technical Assistance/Capacity Building					
Program Contract	-	21,591	-	21,591	17,926
Program Implementation & Oversight	-	23,974	-	23,974	-
Legal	-	241	-	241	-
PEI State Wide Program Funding:					
Program Expense:					
Program Contract	-	-	19,886,057	19,886,057	6,271,439
Program Mgmt. & Oversight	-	-	824,107	824,107	-
Legal	-	-	6,216	6,216	30,729
Meeting and Other	-	-	33,273	33,273	10,937
Evaluation Expense:				-	
Program Contract	-	-	1,269,056	1,269,056	988,249
Program Mgmt. & Oversight	-	-	42,262	42,262	-
Meeting and Other	-	-	3,356	3,356	-
Planning Expense:					
Program Mgmt. & Oversight	-	-	112,698	112,698	1,351,918
Other Contract Services	-	-	20,124	20,124	137,191
Legal	-	-	-	-	100,727
Marketing	-	-	164,388	164,388	-
Meeting and Other	-	-	942	942	109,858
Total Program Expense	-	45,806	22,362,479	22,408,285	9,018,974
INDIRECT EXPENSES:					
General Management	55,202	1,262	429,663	486,127	-
Other Contract Services	7,344	-	43,257	50,601	1,468
Legal Services	28,620	-	33,776	62,396	-
Insurance	-	-	32,374	32,374	29,938
Investment Management Fees	94,384	-	-	94,384	24,454
Marketing	-	-	48,517	48,517	-
Meeting and Other	21	-	84,749	84,770	12,499
Formation Fees	-	-	56,625	56,625	-
Total General And Administrative	185,571	1,262	728,961	915,794	68,359
Total Expenses	185,571	47,068	23,091,440	23,324,079	9,087,333
(Loss) Income from Operations	(185,571)	457,643	(23,091,440)	(22,819,368)	28,980,216
FORMATION FEE ALLOCATION	-	9,695	(9,695)	-	-
NONOPERATING INCOME:					
Investment Income	1,271,057	-	-	1,271,057	395,409
Change in Investment Value	(779,656)	-	-	(779,656)	(166,985)
Total Nonoperating Income	491,401	-	-	491,401	228,424
Change in Net Assets	305,830	467,338	(23,101,135)	(22,327,967)	29,208,640
Beginning Net Assets	318,063	48	128,402,218	128,720,329	104,608,021
Ending Net Assets	$ 623,893	$ 467,386	$ 105,301,083	$ 106,392,362	$ 133,816,661

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

UNAUDITED
STATEMENT OF CASH FLOWS

For the Nine Months Ended, March 31, 2013 and March 31, 2012

	2013	2012
Cash Flows from Operating Activities:		
Cash Payments for Technical Assistant/Capacity Building	$ (465,404)	$ -
Cash Payments for PEI State Wide Program Funding	(22,714,667)	(8,049,524)
Cash Payments for Planning Expense	(289,638)	(1,726,376)
Cash Payments for Evaluation Expense	(1,384,426)	(577,197)
Cash Payments for Indirect Expenses	(732,283)	(31,406)
Cash Payments for General & Administrative Expenses	(141,724)	(24,454)
Cash Payments Received for PEI Community Planning	11,250	2,557,145
Cash Payments Received for Program Funding	213,750	48,585,755
Cash Payments Received for Technical Assistant/Capacity Building	160,700	-
Cash Payments Received for WET Program	-	155,220
Cash Received for Application Fees	250	2,250
Net Cash (Used) Provided by Operating Activities	(25,342,192)	40,891,413
Cash Flows from Investing Activities:		
Cash Received for Investment Income	1,300,466	239,328
Cash Received for Investment Maturity	46,787,038	-
Cash Payments for Purchases of Investments	(37,341,719)	(91,297,753)
Net Cash Provided (Used) by Investing Activities	10,745,785	(91,058,425)
Net Change in Cash and Cash Equivalents	(14,596,407)	(50,167,012)
Beginning Cash and Cash Equivalents	39,436,531	91,445,563
Ending Cash and Cash Equivalents	$ 24,840,124	$ 41,278,551

Reconciliation of Operating Income to Net Cash Provided by Operating Activities:	2013	2012
Operating (Loss) Income:	$ (22,819,368)	$ 28,980,216
Adjustment to net cash used by operating activities:		
(Increase) Decrease in Accounts Receivable	(118,761)	13,090,100
Decrease (Increase) in Contractor Prepayments	1,356,823	(3,924,567)
(Decrease) Increase in Accounts Payable	(3,760,886)	2,590,444
Increase in Unearned Revenue	-	155,220
Net Cash (Used) Provided By Operating Activities	$ (25,342,192)	$ 40,891,413

Supplementary Information

Noncash Financing and Investing Activities:		
Decrease in Fair Market Value of Investment	(779,656)	(166,985)

California Mental Health Services Authority (CalMHSA)

Professional Services Agreement

1. Identification of Parties:

THIS AGREEMENT is effective by and between Contractor (identified at the end of this Agreement) and the California Mental Health Services Authority (CalMHSA). Contractor understands that George Hills Company (GHC) manages the California Mental Health Services Authority (CalMHSA) and that the services to be provided under this contract are for the benefit of CalMHSA.

2. Service Agreement Representative:

The CalMHSA representative for the performance of the scope of services will be Ann Collentine, Program Director. The representative for the Contractor will be __________. Contractor will report to the Program Director. John Chaquica, Executive Director of CalMHSA, will be the signor and responsible for the contractual provisions of this Agreement.

3. Term of Contract:

This Agreement shall be effective on ________ through 6/30/13. This Agreement may be extended for one-year periods upon written agreement of both parties. Either party may cancel the agreement (including extensions to the agreement) upon 30 day written notice to the other party, for any reason whatsoever or for no reason at all, consistent with the provisions of Section 9 below.

Contractor shall not subcontract, assign or delegate any portion of this Agreement or any duties or obligations hereunder without CalMHSA's prior written approval.

4. Scope of Contractor's Work:

The Contractor will serve as a Consultant as described below and at the specific direction of the Program Director:

To serve as a part-time consultant to the California Mental Health Services Authority (CalMHSA) on a variety of issues related to the successful implementation of Statewide Prevention and Early Intervention (PEI) Mental Health Programs. Contractor will provide leadership and program expertise to assist CalMHSA staff in the management of Suicide Prevention and Student Mental Health, and support the regional and local application of Statewide Stigma and Discrimination Reduction, Suicide Prevention and Student Mental Health efforts.

In addition to working with County Mental Health staff, key stakeholders in the region and the contractors implementing CalMHSA projects, Contractor will provide guidance

SAMPLE

and expertise to support CalMHSA program staff. A matrix of key organizations with whom the contractor will communicate and coordinate is attached.

Specific Consultant Functions:

a. Provide leadership and direction to the implementation of multi-county programming in the field. This involves meeting and communicating with County staff, Advisory Committees, program partners, and other stakeholders, to ensure programming is coordinated across initiative areas.
b. Liaison with CalMHSA program staff to monitor contract performance of the regional contractors and/or CalMHSA. Provide written recommendations to the Contract Manager related to contract performance, program improvement, areas for coordination and synergy between projects, and opportunities to leverage available resources.
c. Provide leadership and direction within the region to assure that CalMHSA principles, organizational standards and policies are maintained and followed. This includes, but is not limited to, assuring that program goals are achieved throughout the region in a timely manner.
d. Liaison with CalMHSA program staff and contractors to identify technical assistance needs related to implementation. Provide technical assistance to program partners as needed.
e. Provide recommendations on how the reach of CalMHSA programs can be enhanced to serve new member counties, while actively encouraging providers to focus on the cultural and language needs of the diverse populations served.
f. Contractor will provide bi-weekly written reports of outcomes achieved and activities with county staff, program partners and other stakeholders, utilizing formats provided by CalMHSA.

Contractor will attend the following meetings:

g. An orientation to be scheduled by CalMHSA, and subsequent Statewide Coordination Workgroup (SCW) meetings.
h. Quarterly in-person meetings in Rancho Cordova to collaborate with CalMHSA staff and the team of contract specialists.
i. Key meetings within the region (e.g. suicide prevention task force, CCSESA regional, others identified by consultant and/or CalMHSA staff).

Regular communication with CalMHSA staff and the team of contract specialist is required and will be accomplished through a combination of conference calls, emails and other forms of communication as requested by CalMHSA.

5. Compensation and Terms of Payment: ___________ through June 30, 2013:

SAMPLE

Contractor will receive compensation as follows:

a. Monthly compensation of $_________, which includes all lodging and out-of-pocket expenses, but not mileage.
b. Mileage reimbursement for necessary travel within the Region.
c. Reimbursement for any reasonable travel, lodging and out-of-pocket expenses related to mandatory meeting attendance identified in item 4. g and h above, with prior approval from Program Director. (See attached travel guidelines.)

In order to receive any payment, Contractor agrees to submit monthly invoices in format provided by CalMHSA, detailing work performed, indicating the total professional fees due to the Contractor. CalMHSA agrees to pay the Contractor the billed amount within 30 days of receipt of the invoice.

6. Confidentiality:

In the course of performance under this contract, information and data of a confidential or proprietary nature may be disclosed to the Contractor. Contractor agrees to accept such data in confidence, to not to disclose such data to others, to comply with all appropriate state and federal confidentiality laws, and to refrain from using such data for purposes other than those directed hereunder by CalMHSA. Contractor shall be governed by all statutory guarantees of client confidentiality in handling any documents related to specific clients.

7. Liability:

Neither GHC nor CalMHSA shall in any way be held liable for any accident, personal injury, or property damages caused or incurred by Contractor. Contractor hereby agrees to indemnify and hold harmless GHC and CalMHSA from any claims or actions arising in any way from the acts or omissions of Contractor, even if George Hills Company and/or CalMHSA were also negligent.

8. Independent Contractor:

Contractor in the performance of this Agreement is an independent contractor. Contractor understands and agrees that Contractor shall not be considered officers, employees or agents of GHC/CalMHSA.

Contractor assumes full responsibility for their acts and/or omissions as they relate to the services to be provided under this Agreement. Contractor is solely responsible for payment of all federal, state and local taxes or contributions, including unemployment insurance, social security and income taxes.

The Contractor will sign CalMHSA's confidentiality agreement prior to commencing work.

SAMPLE

9. Early Termination:

CalMHSA reserves the right to suspend, terminate or abandon the execution of work by Contractor without cause at any time upon giving to Contractor 30 days' written notice. In the event that CalMHSA should abandon, terminate or suspend Contractor's work without cause, Contractor shall be entitled to payment for services provided prior to the effective date of said suspension, termination or abandonment, consistently with the provisions of this contract. If CalMHSA terminates the Agreement because Contractor has failed to perform as required under the Agreement, CalMHSA may recover or deduct from amounts otherwise owing under the Agreement any costs it sustains resulting from Contractor's breach. Upon receipt of notice of termination, Contractor shall stop work as of the date specified, and transfer to CalMHSA any materials which, if the Agreement had been completed or continued, would have been required to be furnished to CalMHSA.

Contractor: Name of Consultant

Tax Identification Number: ____

License Number (If Applicable): ____

Name and Title: ____

Signature: _____________________________________ Date:______________________

CalMHSA:

Name and Title: ____________John E. Chaqüica, President_______________________

Signature:_______________________________________ Date: ____________________

SAMPLE

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY
"CalMHSA"
STANDARD SERVICES AGREEMENT AMENDMENT

This Agreement is a contract amendment by and between the California Mental Health Services Authority ("CalMHSA") and RAND Corporation (Contractor).

CalMHSA desires to obtain services which are more fully described in Exhibit E to "Contract Amendment for Training, Technical Assistance and Capacity Building Services, Phase II and III", Agreement No. EVAL-RAND-01-A4, and Contractor represents that it is willing and professionally qualified to provide such services to CalMHSA.

The parties agree that work to be performed under the original contract remains subject to the term and maximum payment amounts stated.

The parties agree that the contract is amended to add:

- ☑ Exhibit E – An additional statement of work
- ☑ Attachment 1 to Exhibit E - Budget Form and Narrative, which supersedes the prior version
- ☑ Attachment 2 to Exhibit E- Table of Contributing Counties and Contract Amendment Maximum

The following term and payment limits apply: The maximum amount payable for work under this Amendment (Exhibit E) is the total stated in Attachment 2 (Contributing Counties and Contract Amendment Maximum) by fiscal year, as it may be amended from time to time. This Amendment only contains revisions to initial Agreement; therefore verbiage not being changed will not be repeated.

While this Amendment is negotiated and executed, work shall continue under the existing Agreement. Any work performed pursuant to the provisions of this Amendment prior to its execution shall become compensable if and when the Amendment is executed. Except as set forth in this Amendment, the Agreement is unaffected and shall continue in full force and effect in accordance with its terms.

The term for work under this Amendment is 7/1/2012 through 6/30/2014.

CalMHSA

Signed: ______________________________ Name (Printed): John E. Chaquica
Title: CalMHSA Executive Director Date: ______________________________
Address: c/o George Hills Company, 3043 Gold Canal Drive, Rancho Cordova, CA 95670
Phone: (916) 859-4800 Email: john.chaquica@georgehills.com

Signed: ______________________________ Name (Printed): Wayne Clark, PhD
Title: CalMHSA President Date: ______________________________

CONTRACTOR

Signed: ______________________________ Name (Printed): Dennis Flieder___________________________
Title: Director, Contract & Grant Services__ Date: ____________________________________
Address: 1776 Main Street / PO Box 2138, Santa Monica, CA 90407-2138_________________________
Phone: 310-393-0411, ext. 6724__________ Email: flieder@rand.org______________________________

Rationale for Amendment Request

Phase II and III Program Deliverables

The purpose of this contract amendment is to revise the budget based on contributions from counties for fiscal years 2013-14 and 2014-15. The counties that are contributing to this program are the priority counties to receive training, technical assistance and capacity building services. A listing of the contributing counties and their contributions are provided in Attachment 2 to this Exhibit E, Contributing Counties and Contract Amendment Maximum. In addition, based on county feedback, the scope of work has been revised for Phases II and III of the program.

TTACB funds are subject to reversion; key deliverables must be completed by June 30, 2013 and June 30, 2014 and shall result in funds being expended prior to those dates. The purpose and deliverables of Phases II and III will be driven by RAND expertise, and input from CalMHSA, counties and other stakeholders. Phase II is the delivery of group and individualized training and technical assistance identified by counties, and facilitation of ongoing regional workgroup meetings. Phase III will focus on providing regional technical assistance to community based organizations and training to stakeholders, with an end goal of improving community capacity to understand and utilize program data and inform decision-making. In formulating specific tasks RAND will seek feedback from counties participating in the program. The workplans that will be developed will serve as the guiding documents for the program through June 30, 2014.

REVISIONS to EXHIBIT E

Contract Amendment for Training, Technical Assistance and Capacity Building Services, Phases II and III

1. Contractor Contact information is being replaced by the following:

Dennis Flieder, Director, Contract and Grant Services
RAND Corporation
1776 Main Street, Box 2138
Santa Monica, CA 90407-2138
310-393-0411 x6724
310-451-6973 fax

2. Deliverable No. 4.2: Develop and facilitate regional workgroups, is replaced by the following:

Deliverable No. 4.2: Develop and facilitate regional and topic focused workgroups, webinars or other suitable vehicles for providing technical assistance.

4.2.1. Obtain input from contributing counties regarding how to best structure regional workgroup and technical assistance meetings.
4.2.2. Develop topic-focused workgroups, with participation based on county interest, to include Community Based Providers and recipients of services as determined by each contributing County.
4.2.3. Plan and facilitate topic-focused workgroup meetings at least two times per fiscal year. Workgroups will be repeated in different regions in order to deliver content to contributing counties.
4.2.4. Provide training, technical assistance and capacity building services in workgroup settings, based on input from counties regarding their needs.
4.2.5. Provide opportunities for counties to share their experiences and engage in peer-to-peer exchange, coordination and problem-solving. Provide opportunities for coordination among county and partner efforts.
4.2.6. Develop a document summarizing regional work group activities and findings.
4.2.7. In conjunction with these technical assistance activities, develop toolkits and other resource materials and make this information publicly available.

Summary, Deliverable #2: Develop topic-focused workgroups that include county staff and their designees (to include Community Based Providers and recipients of services as determined by each County). In order for regional workgroups to be useful and productive for counties, RAND will obtain county input regarding factors such as which counties make up each region, meeting locations, date, time, frequency, duration and options for participation (including videoconferencing and/or webinars). Initial county input suggests that travel, particularly overnight travel, is a challenge for many counties. The location of regional workgroup meetings will be designed to maximize participation with an emphasis on counties contributing to the project. Initial county feedback suggests that full day workgroup meetings are the best use of

county time and travel resources. It may be effective to couple the TTACB workgroup meetings with other standing meetings, such as Workforce, Education and Training meetings, and to utilize technology (e.g. webinars) to minimize travel burden to counties. Consider how the workgroups can build upon existing workgroups, such as those for the Full Service Partnerships and CMHDA IDEA Ad Hoc Committee, in order to promote coordination and sustainability.

RAND and CalMHSA will request input from counties regarding which topics are of the highest priority for the regional workgroup meetings. Initial county input suggests that training, technical assistance and capacity building should address topics such as how to analyze PEI data (statistical analysis), a progression from process outcomes and outputs to analyzing program outcomes, how reporting can be standardized across programs and providers, how data can be used for program improvement, how to utilize Electronic Health Record software to store and analyze PEI data and how to track community level indicators. The workgroup meetings will also contain an opportunity for counties to identify common areas of interest and capacity to participate in statewide evaluation activities.

Initial county input suggests that workgroup meetings should contain a mix of activities, for example: peer to peer exchange, training, technical assistance, topical breakout sessions, and opportunities for one-on-one consultation. Peer learning may be most effective and relevant when county efforts share commonalities. RAND will work with counties to identify common programs and topics, and will facilitate opportunities for counties to receive training, technical assistance and share information in these areas. Peer exchange and learning sessions will include the opportunity to:

- Share best practices in tracking, analyzing, reporting, and utilizing PEI data.
- Discuss challenges to working with data, sharing data, and using it for planning.

Based on initial county feedback, it may be useful for some workgroup efforts to occur across regions and be focused on a topical area (e.g. the development of integrated data systems). RAND will help counties to connect based on common interest areas and will facilitate topical workgroups.

In the process of developing workgroups and other vehicles for technical assistance, RAND will develop toolkits or other resource materials. These resources will be made publicly available so that counties, community based providers and other interested parties may access and utilize them.

3. **Deliverable No. Deliverable No. 4.3: Assist counties in strategies to engage stakeholders in utilizing data to drive decision making. Provide recommendations on how to disseminate data and evaluation results to stakeholder groups, is replaced by the following:**

4.3.1 Work with counties to understand their needs related to communicating with a variety of stakeholder audiences.
4.3.2 Develop draft tools and templates for use by counties in disseminating evaluation results to a variety of stakeholder audiences.
4.3.3 Develop and deliver content that builds the capacity of counties, community based organizations and stakeholders in utilizing data to drive decision making.

Summary, Deliverable #3: Initial county input suggests that counties would like assistance on how to disseminate data and evaluation findings in a way that is meaningful to their communities. This assistance may include developing report templates for different stakeholder subgroups (e.g. Board of Supervisors, Local Mental Health Boards, consumers and family members, service providers), strategies for sharing data in public forums and for making evaluation findings accessible for all stakeholders. RAND will develop and deliver content (e.g. via webinar), tools and report templates for use by counties.

4. Deliverable No. 4.4: Develop systems and provide small group or one-on-one evaluation consultation and training, technical assistance and capacity building services to contributing County staff and/or their designees, is replaced as follows:

4.4.1 Based on needs assessment findings and follow-up conversations with counties, identify county needs that will be addressed through small group and/or one-on-one consultation.
4.4.2 Work with CalMHSA and counties to prioritize county training, technical assistance and capacity building service requests based on agreed upon criteria:

- The counties' financial contribution to the program (see Attachment 2 to this Exhibit E),
- The scope of the requested service, and,
- RAND staff resources required to fulfill the request.

4.4.3 Provide small group and/or one-on-one training, technical assistance and capacity building services to counties, based on the priorities determined in 4.4.2.
4.4.4 Develop mechanisms for counties to ask evaluation questions and receive support from RAND staff via telephone and email.

Summary, Deliverable #4: In many cases, counties have expressed that they do not have adequate staff time to carry out critical evaluation functions and are looking to RAND to substantially assist with performance of duties. These activities may include the identification of measurement tools, assistance with interpreting data sets, statistical analysis, development of report templates, development and delivery of stakeholder training, or other individualized evaluation functions as identified by counties.

RAND is tasked with working with each county that is contributing to this program to identify specific technical assistance, training and/or capacity building needs. RAND will work with CalMHSA and the contributing counties to prioritize the county requests for services, based on criteria such as the counties' financial contribution to the program (see Attachment 2 to this Exhibit E), the scope of the requested service and RAND staff resources required to fulfill the request. RAND will then deliver a level of service that is agreed upon between CalMHSA and

the county. A list of contributing counties and their level of participation is provided in Attachment 2 to this Exhibit E.

It is imperative that counties that are financially contributing receive training, technical service and capacity building services that are provided in a format that meets their needs and travel constraints (e.g. may require in-person assistance in their community). In addition, RAND will provide counties with opportunities to receive technical assistance via telephone and email.

5. Deliverable No. 4.6: Contract Monitoring and Reporting, is replaced by the following:

4.6.1 RAND will report on all outcomes from the elements of the plan for which they are responsible.
4.6.2 RAND will input data remotely using a variety of devices.
4.6.3 RAND will be responsible for managing the aggregate database, responding to requests for data from CalMHSA and disseminating regular reports to CalMHSA and its members.
4.6.4 Prior to print or publication, RAND will provide draft copies of reports and other written materials to CalMHSA staff for review and comment.

Summary, Deliverable #6: RAND will comply with contract reporting requirements developed by CalMHSA and will report quarterly to CalMHSA through the provided CRM. RAND will attend meetings and coordination workgroups to ensure that opportunities are not missed and efforts are not duplicated. Based on dates, deadlines and deliverables that are established in the work plan, RAND will report on all outcomes from the elements of the plan for which they are responsible. CalMHSA will use standardized data collection instruments with a portal for use by RAND that will ultimately allow CalMHSA to download and compile the data records to provide views of activities and achievements for contract deliverables. RAND will input data remotely using any of a variety of devices, including Windows Mobile-based Pocket PCs and a Web browser or laptops that are compatible with Microsoft Dynamic CRM.
RAND will be responsible for managing the aggregate database, responding to requests for data from CalMHSA and disseminating regular reports to CalMHSA and its members through the Microsoft Dynamic CRM platform provided by CalMHSA.

6. Deliverable No. 4.7: Develop a workplan for the remainder of the TTACB program, is added to include the following:

4.7.1. Review feedback and requests for technical assistance from contributing counties. Elicit revised program priorities from these counties by June 30, 2013.
4.7.2. Consider how TTACB efforts can complement the evaluation efforts already underway at counties. Develop a workplan for the remainder of the TTACB program with clear outcomes by July 30, 2013.
4.7.3. Obtain approval of the workplan from CalMHSA by August 15, 2013.

Summary, Deliverable # 7: In order to provide training, technical assistance and capacity building services that are relevant to the needs of contributing counties, RAND will interface with counties to elicit information regarding their current capacity and needs.

Develop a workplan for the remainder of the TTACB program that describes group and individual technical assistance activities, frequency of activities and sets a schedule and

expectations for the remainder of the contract period. RAND will work with CalMHSA to obtain approval on the workplan, which will be guided by county feedback.

7. The budget and payment terms pertaining to <u>This Contract Amendment</u> are as follows:

Funds for this contract have been committed by participating counties. Attachment 1 to this Exhibit E is the RAND budget for this contract amendment.

Attachment 2 to this Exhibit E is a chart of the funds currently committed. The parties anticipate that the chart will be updated as county contribution levels change. RAND will utilize the available funds (as stated by the then-current version of Attachment 2) consistent with the provisions of Attachment 1, with the understanding that Deliverables 2 and 3 are relatively fixed obligations while obligations under Deliverable 4 are expected to change as counties change their level of financial participation in the program.

ATTACHMENT 1

Budget Form and Narrative is Replaced by the Following:

	BUDGET CATEGORIES	**BUDGET BY PROGRAM Year** (Show budget for each project. Copy form for adding 3+ Programs)			
		Year 1	**Year 2**	**Year 3**	**TOTAL**
	I. DIRECT COST				
A.	**PERSONNEL-ADMINISTRATIVE/SUPPORT STAFF**				
	1. Program Staff				
	Principal/Lead Researchers (Burnam, Berry) (labor and fringe)	$29,825	$42,504	$39,323	$111,652
	Other Research	$91,070	$75,245	$69,695	$236,010
	2. Administration/Support	$5,349	$25,604	$23,560	$54,513
	3. Research Management Costs*	$87,520	$107,738	$114,496	$309,754
B.	**SERVICES AND SUPPLIES**				
	1. Stakeholder Web Conference				
	2. Publications				
	3. Miscellaneous Expense				
	Misc Costs to Host Stakeholder Meetings				
	Other Miscellaneous Costs				
	4. Travel				
	Travel for Program Support and Stakeholder Meetings		$12,185	$12,456	$24,641
	Travel for Preliminary Visit; Workshop Training	$11,155			$11,155
	5. Other (Specify)				
	Survey		$3,837	$1,059	$4,896
	Computing Services--computing	$9,677	$10,312	$9,129	$29,118
	Data Entry—data entry	$10,056			$10,056
	Miscellaneous Costs	$5,057	$2,394	$1,449	$8,900
	Other Data Acquisition				
	Subcontract				
	UCLA				
	SRI	$120,000	$80,647	$68,860	$269,507
C.	**EQUIPMENT**				
D.	**FACILITY COSTS**				
	SUBTOTAL				
	II. INDIRECT COSTS				
A.	**ADMINISTRATIVE FEE**	$32,963	$31,870	$28,818	$93,651
B.	**TOTAL OTHER INDIRECT COSTS**	$42,328	$37,909	$20,205	$100,442
	SUBTOTAL	$75,291	$69,779	$49,023	$194,093
	TOTAL BUDGET	$445,000	$430,245	$389,050	$1,264,295

** These cost estimates are based on an analysis of the work to be undertaken and the cost experience of similar RAND projects. Personnel costs include all required items, with exception of Other Direct Costs listed. There are a number of individuals that must support a research project. RAND research management assists projects with regular and routine project review that include briefings by project staff. They also aid staff with methodology development, problem solving and suggest redirection when needed. Other reviews are focused on the appropriateness of the process, its quality, relevance and policy impact. Financial aspects of the project require constant attention from budget monitors, grant administrators, and accountants. Assistance from Human Resources staff is not unusual. Actual costs will be accumulated in accordance with RAND's audited accounting procedures. For financial reporting purposes, personnel costs will be reported by aggregate.*

Budget Narrative

Technical Assistance to Counties Budget Narrative for Year 2 and Year 3

1. Program Staff

Senior Behavioral Scientist allocated a total of 38 days in Year 2 and 30 days in Year 3; responsible for overall leadership of this task and providing technical assistance to California counties on PEI evaluations.

One Senior Natural Scientist (allocated 27 days in Year 2 and 26 days in Year 3), one Senior Behavioral Scientist (2 days in Year 2 and 5 days in Year 3), one Project Associate 5 (38 days in Year 2, 35 days in Year 3) to provide technical assistance, including an assessment of county needs, facilitation of regional workshops, development of strategies to engage local stakeholders, and a work plan for Phases II and III for each region.

One Project Associate 4 allocated at 4 days in Year 2 for additional research and project management support.

One Project Associate 3-Tech allocated at 20 days in Year 2 and 15 days in Year 3 for developing and maintaining database and related materials.

Senior Researcher TBN for 4 days to provide peer review of documents in Year 2.

Two Administrative Assistant IV allocated at 77 days in Year 2 and 70 days in Year 3 for support of staff communications and development of draft documents, workshop and webinar materials as well as supporting invitations and tracking of participants in TA events, communications with participants, arranging travel and setting up meeting facilities.

*Research Management Costs are cost estimates based on an analysis of the work to be undertaken and the cost experience of similar RAND projects. Personnel costs include all required items, with exception of Other Direct Costs listed. There are a number of individuals that must support a research project. RAND research management assists projects with regular and routine project review that include briefings by project staff. They also aid staff with methodology development, problem solving and suggest redirection when needed. Other reviews are focused on the appropriateness of the process, its quality, relevance and policy impact. Financial aspects of the project require constant attention from budget monitors, grant administrators, and accountants. Assistance from Human Resources staff is not unusual. Actual costs will be accumulated in accordance with RAND's audited accounting procedures. For financial reporting purposes, personnel costs will be reported by aggregate.

2. Travel

$12,185 in Year 2 and $12,456 in Year 3 allocated for site visits, individual technical assistance, regional workshops, and trips to Sacramento for consultation with CalMHSA.

3. Computing Support and Technology Services Allocation

Computing Services consist of the following:

Computing Support. The computing support category includes the acquisition, use and maintenance of hardware and software. It includes systems programmers' services to support the use of the computer systems. Service support includes consultation with computer specialists on problem solving, documentation, and product support, as well as routine backup of working files so that information can be retrieved if it is deleted in error or as the result of a system failure. Computing support services are budgeted at a rate of $4,520 per FTE (full time equivalent) per year. The allocation reflects the full service and support costs for all staff and includes all hardware, hardware maintenance, software, software support, file backups, and all other services provided by the RAND Computing Department's analysts for the project period, plus inflation. Computing services are budgeted at $10,312 in Year 2 and $9,129 in Year 3.

Technology Services Allocation. This category covers the project-related expenses for operation and maintenance of duplication and copying systems for inter- and intra-institution dissemination (e.g., correspondence, manuscripts, related publications), video-conferences, web-meetings, and telephone costs.

Technology Services Allocation is $10,312 in Year 2 and $9,129 in Year 3. Based on staff time and further escalated for inflation.

Miscellaneous costs include working lunches, postage, shipping and other costs associated with providing work groups and are budgeted at $2,394 in Year 2 and $1,449 in Year 3.

4. Other Direct Costs

Survey costs are budgeted at $3,837 in Year 2 and $1,059 in Year 3 to cover development of data entry instruments.

Subcontract to SRI is budgeted at $80,647 in Year 2 and $68,860 in Year 3.

6. Indirect Costs

<u>Indirect Cost Rate</u>

Indirect rate is listed at 15% to applicable Total Direct Costs

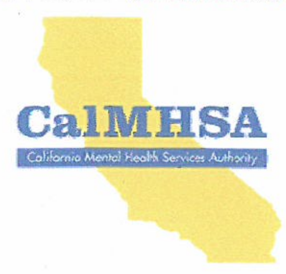
ATTACHMENT 2

Contributing Counties and Contract Amendment Maximum is as Follows:

The following counties are contributing to this program and are the priority counties to receive training, technical assistance and capacity building services, per their contribution rates in Table 1.

Table 1. Contributing Counties and Contract Amendment Maximum		
Contributing Counties	**Contribution through 6/30/13**	**Contribution through 6/30/14**
Inyo	$2,100	$2,100
Lake	$8,900	$8,900
Los Angeles	$300,000	$300,000
Marin	$10,711	
Modoc	$1,200	$1,200
Monterey	$76,301	$68,400
Placer	$22,794	
Solano	$61,200	$61,200
Yolo	$31,200	$31,200
Subtotal	$514,406	$473,000
Less CalMHSA Administrative Fee[1]	$77,160.90	$70,950.00
Less TTACB Professional Services Agreement	$7,000.00	$13,000.00
Total- Contract Amendment Maximum	$430,245.10 (Fiscal Year 12-13)	$389,050.00 (Fiscal Year 13-14)

[1] The administrative rate charged to this program will be determined by the CalMHSA Finance Committee and will cover costs associated with program planning, administration and evaluation. In the interim, until the actual rate has been determined, an administrative rate of 15% has been included as a placeholder.



New Member Data Fee Form
California Mental Health Services Authority

3043 GOLD CANAL DRIVE, SUITE 200 ✦ RANCHO CORDOVA, CA 95670 ✦ PHONE: (916) 859-4800 FACSIMILE: (916) 859-4805

County Information

	Population	Date Population Recorded
I. **Population Information**: (Based on most recent population published by State Department of Finance)	1,530,000	2011

II. **Application Fee Schedule** (*Based on most recent population published by State Department of Finance*)

- ☐ Population greater than 10 million: $1,000
- ☑ Population 1 million to 10 million: $ 750
- ☐ Population 100,000 to 1 million: $ 500
- ☐ Population less than 100,000: $ 250

☑ *Please issue warrant to California Mental Health Services Authority* $750.00

OR

☐ *Application Fee will be paid upon the first reassignment of program funds to CalMHSA*

III. **Requested Date of Membership:** July 1, 2013

County/City

Alameda County

Printed Name

Aaron Chapman, M.D.

Signature

6.5.13

Date

Please complete form and submit via email to laura.li@georgehills.com. Print and/or save completed form for your records.

Current Membership Roster

50 members (49 counties, 1 JPA, 1 City)

- San Bernardino County (July 9, 2009)
- Solano County (July 9, 2009)
- Colusa County (July 9, 2009)
- Monterey County (July 9, 2009)
- San Luis Obispo County (July 9, 2009)
- Stanislaus County (July 9, 2009)
- Sutter/Yuba County (August 13, 2009)
- Butte County (November 13, 2009)
- Placer County (January 14, 2010)
- Sacramento County (March 12, 2010)
- Glenn County (April 7, 2010)
- Trinity County (April 15, 2010)
- Sonoma County (May 13, 2010)
- Modoc County (May 13, 2010)
- Santa Cruz County (June 10, 2010)
- Los Angeles County (June 10, 2010)
- Marin County (August 12, 2010)
- Orange County (August 12, 2010)
- Yolo County (August 12, 2010)
- Contra Costa County (October 14, 2010)
- Fresno County (October 14, 2010)
- Imperial County (October 14, 2010)
- Kern County (October 14, 2010)
- Lake County (October 14, 2010)
- Riverside County (October 14, 2010)
- Santa Clara County (October 14, 2010)
- Siskiyou County (October 14, 2010)
- Ventura County (October 14, 2010)
- Madera County (November 12, 2010)
- Mendocino County (December 9, 2010)
- San Diego County (February 10, 2011)
- San Francisco City & County (February 10, 2011)
- El Dorado County (March 11, 2011)
- San Mateo County (March 11, 2011)
- Napa County (June 9, 2011)
- Humboldt County (July 14, 2011)
- Lassen County (July 14, 2011)
- Mariposa County (August 11, 2011)*
- Tuolumne County (August 11, 2011)
- San Benito County (October 13, 2011)*
- Tri-City Mental Health Center (October 13, 2011)
- Del Norte County (December 15, 2011)*
- Shasta County (February 10, 2012)*
- Tulare County (February 10, 2012)*
- Kings County (April 13, 2012)*
- San Joaquin County (April 13, 2012)§
- City of Berkeley (June 14, 2012)*
- Inyo County (June 14, 2012)
- Mono County (June 14, 2012)
- Nevada County (June 14, 2012)*

Non-Member Counties w/Assigned Funds

Amador, Calaveras, Merced and Santa Barbara

Remaining Non-Member Counties

Alameda, Alpine, Plumas, Sierra and Tehama

CalMHSA's Regional Representatives

Bay Area Regional Representatives	Michael Kennedy, Sonoma County
	Jo Robinson, San Francisco City & County
Central Regional Representatives	Brad Luz, Sutter/Yuba Counties
	Rita Austin, Tuolumne County
Los Angeles Regional Representatives	Marvin Southard, Los Angeles County
	William Arroyo, Los Angeles County
Southern Regional Representatives	CaSonya Thomas, San Bernardino County
	Frank Warren, San Luis Obispo County
Superior Regional Representatives	Karen Stockton, Modoc County
	Anne Robin, Butte County

*Member has elected not to assign funds to CalMHSA.

Updated 6/4/2013

§Member has elected to participate only in the Statewide PEI Suicide Prevention Project, Program 3: Social Marketing Program.

CalMHSA COUNTY OUTREACH

Superior Region

1. **Calaveras** (*assigned funds*), Allan Rawland to follow-up with David Sackman upon to Rita Downs' retirement;

2. **Del Norte,** County staff has reached out to CalMHSA for assistance relative to Statewide PEI projects. Allan Rawland to follow up with county staff.

3. **Amador** (*assigned funds*), they have received BOS approval to pursue membership;

4. **Tehama,** interested in joining; Scott Gruendl and Allan Rawland continue to work Mr. Michael Peña to address questions;

5. **Plumas,** not interested in joining at this time; Allan Rawland to reach out to Kimball Pier;

6. **Sierra**, staff continues to work with Janice Maddox and their County Counsel to address questions as they prepare to present to their BOS;

Central Region

7. **Merced** (*assigned funds*), staff continues to work with Manuel Jimenez to address questions as they prepare to present to their BOS; staff has responded to request for additional information;

8. **Alpine**, interested in joining, Allan Rawland continues to work with Christopher Stewart and Michael Ritter and address all questions;

Bay Area Region

9. **Alameda** (*approved PEI Plan with the City of Berkeley*), received BOS approval and set for CalMHSA Board approval on June 13, 2013;

Southern Region

10. **Santa Barbara** (*assigned funds*), MHD has retired, and staff continues to work with Ms. Garrity to address questions as they consider membership.

Finance Committee Teleconference
Minutes

May 7, 2013

Finance Committee Members

Present

- Mr. Scott Gruendl, Chair, Glenn County
- Mr. Tom Sherry, Sutter/Yuba County
- Dr. William Arroyo, Los Angeles County (not at posted location)
- Dr. Wayne Clark, CalMHSA President (Ex-Officio)
- Tanya Bratton, San Bernardino County

Absent

- Amy Wilner, Butte County

CalMHSA Staff

- John Chaquica, Executive Director
- Kim Santin, Finance Director
- Doug Alliston, Legal Counsel
- Allan Rawland, Associate Administrator – Government Relations
- Maya Maas, Executive Assistant
- Jaikelle Meeks, Administrative Assistant

Consultants

- John T. Liddle, Morgan Stanley Smith Barney
- Deborah Dunn, Morgan Stanley Smith Barney

Members of the Public

- Cynthia Burt, Mental Health Services Oversight and Accountability Commission
- Ren Scammon, El Dorado County
- Michelle Berry, Butte County

The CalMHSA Finance Committee teleconference was called to order at 2:02 p.m. by Committee Chair Scott Gruendl. Introductions were made and teleconference instructions were given by Maya Maas, CalMHSA Executive Assistant.

3. Approval of the Agenda as Posted (Or Amended)
   Committee Chair Gruendl asked for any amendments to the agenda, of which there were none.

   Action: **Approval of the consent calendar.**

   Motion: **Tom Sherry, Sutter/Yuba County**
   Second: **Tanya Bratton, San Bernardino County**

   Motion unanimously approved.

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4. Consent Calendar
Committee Chair Gruendl asked for any changes to the November 26, 2012 minutes or Treasurer's Reports as of December 31, 2012, and March 31, 2013. None were made.

Action: Approval of the consent calendar.

Motion: Tom Sherry, Sutter/Yuba County
Second: Tanya Bratton, San Bernardino County

Motion unanimously approved.

5. CalMHSA Financial Statements for the Quarters Ended December 31, 2012 and March 31, 2013
Committee Chair Gruendl called upon Kim Santin, CalMHSA Finance Director, to give an overview of the Financial Statements for the Quarters Ended December 31, 2012 and March 31, 2013. Ms. Santin reviewed the memo and supporting documentation and emphasized the March Financial Statements, as the most recent statements.

Ms. Santin emphasized the PEI program funding projected net assets, as of March 31, 2013, were $105 million; through June 30, 2013, it is projected there will be $90 million in net assets. Ms. Santin identified this was key because the fiscal modeling at CalMHSA's development were projections for June 30, 2013, to be 75% of these PEI funds expended. We are currently 40% expended; however, implementation is in fact going forward. On the topic of implementation, CalMHSA staff is currently working with Program Partners to collect revised cash flow projections.

Action: Approval of the CalMHSA Financial Statements for the Quarters Ended December 31, 2012 and March 31, 2013 for presentation at the June 13, 2013 Board of Directors Meeting.

Motion: Tom Sherry, Sutter/Yuba County
Second: Tanya Bratton, San Bernardino County

Motion unanimously approved.

6. CalMHSA Investment Update
Committee Chair Gruendl called on John Liddle, Morgan Stanley Smith Barney, to present an update on the CalMHSA investments managed by Public Financial Management (PFM). Mr. Liddle discussed the current interest rate environment and how rising interest rates could affect the portfolio. Mr. Liddle indicated the total projected annual income is approximately $1.3 million and explained how this number includes all the different interest income payments that will be received over the course of the next calendar year. Mr. Liddle explained that he and his team work closely with Kim Santin and the money manager (PFM) to provide the cash flow needed for the current projects. He also explained that any money not being

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spent at the rate initially anticipated can be re-invested, further out on the yield curve to get a higher rate of return than what is currently being earned.

Mr. Liddle noted CalMHSA has been successful at achieving a higher rate of return since March 21, 2012. John Chaquica, CalMHSA Executive Director, reiterated more on the yield curve and gave emphasis to the recommendation being presented.

Action: **Request Morgan Stanley Smith Barney extends investment maturities through June 30, 2015.**

Motion: **Tom Sherry, Sutter/Yuba County**
Second: **Tanya Bratton, San Bernardino County**

Motion unanimously approved.

7. CalMHSA Annual Revenue and Expenditure Report- Proposed Budget June 30, 2014
   Committee Chair Gruendl called on Kim Santin, CalMHSA Finance Director, to provide an overview of the proposed budget for June 30, 2014. Ms. Santin reminded the Committee this budget contains funding through June 30, 2014, and is connected to three programs—Technical Assistance and Capacity Building (TTACB), Prevention and Early Intervention (PEI), and Workforce Education and Training (WET). Ms. Santin noted the total funds projected to be received by June 30, 2014, are $151 million and the estimated interest to be received after the year 2014 is $95,000. Of the $151 million, all will be spent with the exception of $2.9 million of interest income, which will be retained in operating reserve. Mr. Chaquica referenced and elaborated on the budget information provided on page 47 in the agenda packet.

   Action: **Approval of the CalMHSA Revenue and Expenditure Report Proposed Budget June 30, 2014 for presentation at the June 13, 2013 Board of Directors meeting.**

   Motion: **Tanya Bratton, San Bernardino County**
   Second: **Scott Gruendl, Glenn County**

   Motion unanimously approved.

8. George Hills Company Contract - Finance Committee Task Force Update
   Committee Chair Gruendl explained that as result of a meeting between himself, Tanya Bratton, San Bernardino County, and Amy Wilner, Butte County, questions arose regarding George Hills Company, and whether or not their contract should be extended or an RFP process should be established. Mr. Chaquica confirmed all questions and concerns would be answered or solved once the Task Force reconvened to formalize recommendations, and presented to the full Board.

9. Discussion on Statewide Hospital Beds
   Committee Chair Gruendl called on Mr. Chaquica to provide an update on what has been done thus far regarding the planning and development process for the

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Statewide Hospital Beds. Mr. Chaquica reported that CalMHSA has formed a task force to review and consider how each of the counties can work together jointly on a contract and how to operationalize anything relevant to the operation of the hospital beds program. Mr. Chaquica informed the Committee that the staff report included in the agenda packet provided more detailed information on this matter. CalMHSA has been negotiating with Department of State Hospitals (DSH), and have been successful at moving terms and provisions forward in a positive manner. Mr. Chaquica reported rates for beds will not be increased next year, and the Executive Director of Metro Hospital is permitting ICF beds in addition to acute beds. These two items have potential for considerable savings. Negotiations are still underway regarding guidelines for each county purchasing beds and CalMHSA's role. Mr. Chaquica will be meeting with the DSH in early June and anticipates having something tangible and objective to report to the Board Members in June.

The board approved pursuit of the development of the State Hospital Bed Project, outside of the three Statewide initiatives, where in essence the money would come from the participating counties. Each county will need to follow its internal process to approve the costs. Staff is working on a staff report for Los Angeles County as they have the largest share of the costs.

Mr. Chaquica invited further discussion as to how to pay for the development of future projects. One concept being discussed would be to split the development costs between the JPA and interested counties. Tom Sherry, Sutter/Yuba County, suggested low level dues that could help offset development costs as the benefits would affect all members whether they choose to participate fully in a program or not. Committee Chair Gruendl shared the phrasing he used with his board of supervisors explaining he presented the idea as an investment and project specific. He then suggested scheduling further discussion for a future meeting.

10. Finance Committee Teleconference Calendar Fiscal Year 2013-2014
Committee Chair Gruendl reviewed the calendar prepared by staff, and agreed on its contents.

Action: **Approval of the proposed Finance Committee Teleconference Calendar for Fiscal Year 2013-2014**

Committee Chair Gruendl asked if there were any general public or closing comments. Hearing none, the call was adjourned at 3:08 p.m.

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Morgan Stanley

Presentation by John T. Liddle, Senior Vice-President, Morgan Stanley
to
CalMHSA Board of Directors
June 13, 2013

TOPICS

1. Current Interest Rate Environment

2. Present Account Values

    a. Projected Interest Income (see attached report)

    b. Current Portfolio Returns (see attached report)

3. Finance Committee Action – Investment maturities extended to June, 2015

Morgan Stanley Smith Barney LLC. Member SIPC.

Morgan Stanley

Projected Monthly Income - Summary

As of 06/02/2013

CALIFORNIA MENTAL HEALTH
SERVICES AUTHORITY (PFM)
3043 GOLD CANAL DRIVE
SUITE 200
RNCHO CORDOVA CA 95670-6394

Prepared by John T Liddle
Ph. +1 916 567-2030

Acct. 178-116821-451

	Current Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Twelve Month Total
Fixed Income	$87,501	191,325	88,694	144,451	91,025	59,340	113,022	85,575	63,844	144,451	60,013	59,340	82,484	1,183,564
Income Total	$87,501	191,325	88,694	144,451	91,025	59,340	113,022	85,575	63,844	144,451	60,013	59,340	82,484	1,183,564

	Account Totals*	Projected Income	% Yield**
Fixed Income	$81,394,601	$1,183,564	1.45%
Total	$81,394,601	$1,183,564	1.45%

* Account Totals do not include Cash, Cash Equivalents and Annuities.

** Monthly projections are rounded to the nearest dollar and totaled, therefore, % yield calculations are approximate.

The above summary/prices/quotes/statistics/ have been obtained from sources believed reliable but are not necessarily complete and cannot be guaranteed. The information contained in client monthly account statements and confirmations reflects all transactions, and as such supersedes all other reports for financial and tax purposes. This report does not supersede or replace your monthly Client Statement. If we do not hold the securities in a Morgan Stanley Wealth Management account, the report reflects securities which we believe you own, based upon your communications with our Financial Advisor. Investments and services offered through Morgan Stanley Smith Barney LLC, and accounts carried by Citigroup Global Markets Inc., Members SIPC. © 2013 Morgan Stanley Smith Barney LLC

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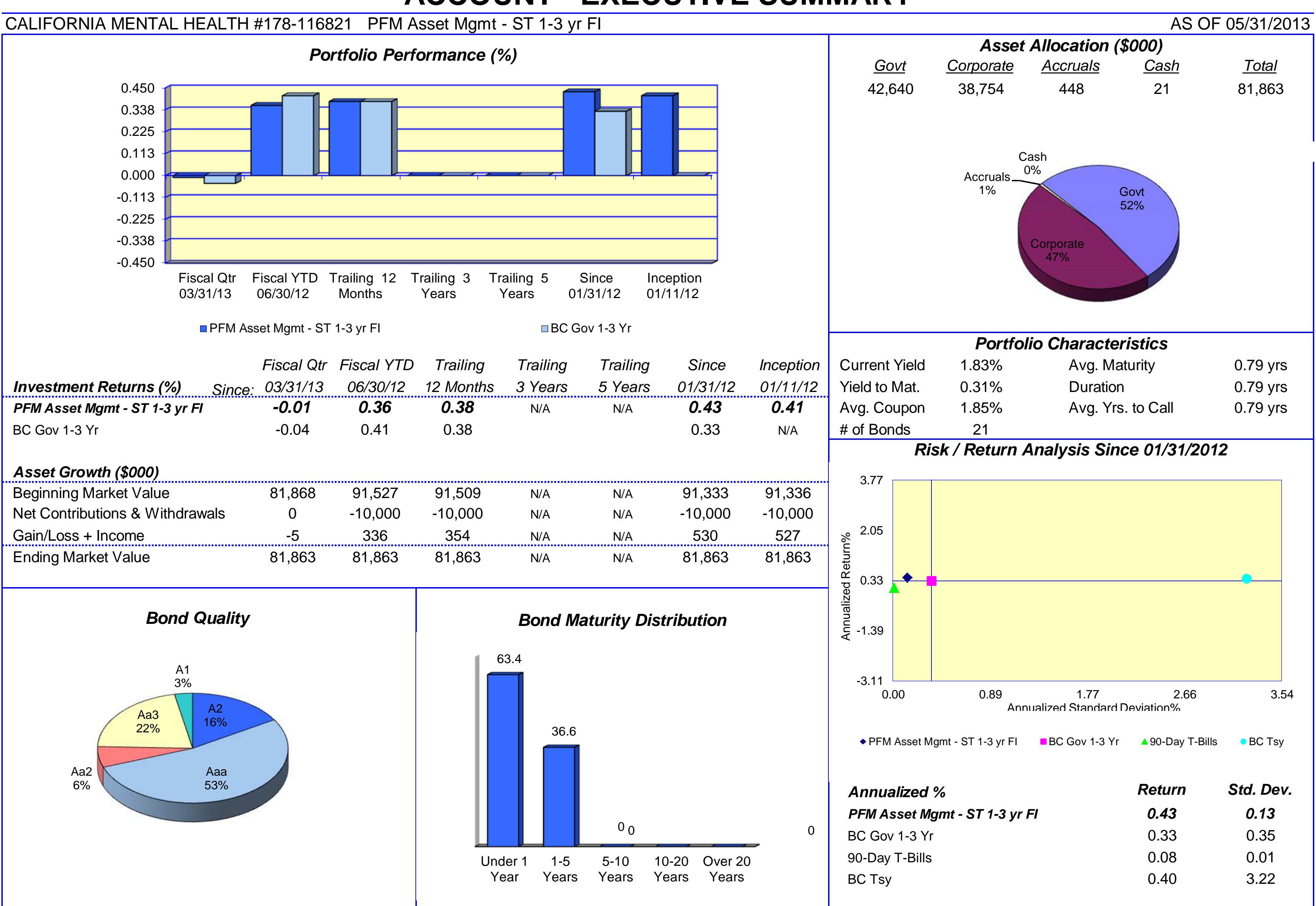
Morgan Stanley

ACCOUNT - EXECUTIVE SUMMARY



CALIFORNIA MENTAL HEALTH #178-116821 PFM Asset Mgmt - ST 1-3 yr FI AS OF 05/31/2013

Portfolio Performance (%)

Investment Returns (%) Since:	Fiscal Qtr 03/31/13	Fiscal YTD 06/30/12	Trailing 12 Months	Trailing 3 Years	Trailing 5 Years	Since 01/31/12	Inception 01/11/12
PFM Asset Mgmt - ST 1-3 yr FI	**-0.01**	**0.36**	**0.38**	N/A	N/A	**0.43**	**0.41**
BC Gov 1-3 Yr	-0.04	0.41	0.38			0.33	N/A

Asset Growth ($000)							
Beginning Market Value	81,868	91,527	91,509	N/A	N/A	91,333	91,336
Net Contributions & Withdrawals	0	-10,000	-10,000	N/A	N/A	-10,000	-10,000
Gain/Loss + Income	-5	336	354	N/A	N/A	530	527
Ending Market Value	81,863	81,863	81,863	N/A	N/A	81,863	81,863

Asset Allocation ($000)

Govt	Corporate	Accruals	Cash	Total
42,640	38,754	448	21	81,863

Portfolio Characteristics

Current Yield	1.83%	Avg. Maturity	0.79 yrs
Yield to Mat.	0.31%	Duration	0.79 yrs
Avg. Coupon	1.85%	Avg. Yrs. to Call	0.79 yrs
# of Bonds	21		

Risk / Return Analysis Since 01/31/2012

Annualized %	Return	Std. Dev.
PFM Asset Mgmt - ST 1-3 yr FI	**0.43**	**0.13**
BC Gov 1-3 Yr	0.33	0.35
90-Day T-Bills	0.08	0.01
BC Tsy	0.40	3.22

Bond Quality

Bond Maturity Distribution

Report Created: 6/3/2013

Please refer to the attached Disclosures for important information.

INVESTMENT PRODUCTS: NOT FDIC INSURED · NO BANK GUARANTEE · MAY LOSE VALUE

Information Disclosures

Please notify your Financial Advisor if there have been any changes in your financial situation or investment objectives, or if you wish to impose any reasonable restrictions on the management of your Investment Advisory accounts, or to reasonably modify existing restrictions.

For a copy of the applicable Form ADV Disclosure Document for Morgan Stanley Smith Barney LLC, or for any Investment Adviser with whom we contract to manage your investment advisory account, please contact your Financial Advisor. These Disclosure Documents contain important information about advisory programs.

Sources and Intent

This investment evaluation is directed only to the client for whom the evaluation was performed. The underlying data has been obtained from sources the Firm believes to be reliable but we do not guarantee their accuracy, and any such information may be incomplete or condensed. This evaluation is for informational purposes only and is not intended to be an offer, solicitation, or recommendation with respect to the purchase or sale of any security or a recommendation of the services supplied by any money management organization. Past performance is not a guarantee of future results. Performance for periods greater than one year is annualized. The information contained herein was prepared by your Financial Advisor and does not represent an official statement of your account at the Firm (or other outside custodians, if applicable.) Please refer to your monthly statement for a complete record of your transactions, holdings and balances.

This Performance Report may show the consolidated performance of some, but not necessarily all, of your Morgan Stanley accounts. In addition, it may show the full performance history of your accounts or just the performance of your accounts since inception in their current Morgan Stanley programs. In some cases, it may show the combined performance of brokerage accounts and advisory accounts. It is important that you understand the combination of accounts and account histories that are included in this Performance Report. Upon your request, performance information can be obtained for other accounts you may have with us, but which are not shown here.

Accounts included in this Performance Report may have had different investment objectives, been subject to different rules and restrictions, and incurred different types of fees, mark-ups, commissions, and other charges. Accordingly, the performance results for this portfolio may blend the performance of assets and strategies that may not have been available in all of your accounts at all times during the reporting period. Please consult your Financial Advisor for more information about the fees and expenses applicable to the accounts included in this Performance Report.

Net Rates of Return

The investment returns in this report for your account as a whole are your net returns after deducting investment management fees and any Select Retirement fees. For more details on fees, please see your client contract, the applicable Morgan Stanley ADV brochure and any applicable Select Retirement prospectus. Returns in excess of one year are annualized. **Select UMA accounts:** If this report is for a Select UMA account, the investment returns shown for the individual investment managers are your gross returns for each manager before deducting investment management fees and any Select Retirement fees. The returns for each manager would be lower if these fees were deducted.

Advisory Notice

The Fiduciary Services-Affiliated Program and the Fiduciary Services-Unaffiliated Manager Program are separate and distinct advisory programs. Absent your written authorization, assets may only be transferred among managers within the particular program.

Bond Average

Please note that all averages calculated are weighted averages meaning that the calculation takes into account the par value of each position. CMO's and Asset Backed securities are excluded from the calculation. Any bonds that are non-rated by both Moody's and S&P are excluded from the average rating calculation.

Fiscal Year

Acct# 178-116821's fiscal year ends on 2013/06

International and Small Capitalization Securities

To the extent the investments depicted herein represent international securities, you should be aware that there may be additional risks associated with international investing involving foreign, economic, political, and/or legal factors. International investing may not be for everyone. In addition, small capitalization securities may be more volatile than those of larger companies, but these companies may present greater growth potential.

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Daily Performance

Beginning January 1, 2005 (former Smith Barney accounts) and July 1, 2011 (former Morgan Stanley accounts), portfolio performance is calculated using a daily valuation methodology, with contributions and withdrawals to the portfolio reflected as of days they were actually made. Portfolio performance for earlier periods reflects various methodologies. Different calculation methods may result in portfolio performance figures that vary from those shown above.

Account Primary Index

Custom Blended Index

The Barclays 1-3 Year Government Bond Index is composed of government bonds with maturities between one and three years.
The current allocation began as of .

The 90-Day Treasury Bill is a short-term obligation issued by the United States government. T-bills are purchased at a discount to the full face value, and the investor receives the full value when they mature. The difference of 'discount' is the interested earned. T-bills are issued in denominations of $10,000 (auction) and $1,000 increments thereafter.
The current allocation began as of .

This BC U.S. Treasury index is the U.S. Treasury component of the U.S. Government index. This index consists of public obligations of the U.S. Treasury with a remaining maturity of one year or more. Exclusions include: Treasury bills are excluded (because of maturity constraint); Certain special issues, such as flower bonds, targeted investor notes (TINs), and state and local government series (SLGs) bonds are excluded; Coupon issues that have been stripped are reflected in the index based on the underlying coupon issue rather than in stripped form. Thus STRIPS are excluded from the index because their inclusion would result in double counting. However, for investors with significant holdings of STRIPS, customized benchmarks are available that include STRIPS and a corresponding decreased weighting of coupon issues; Treasuries not included in the Aggregate Index, such as bills, coupons, and bellwethers, can be found in the index group Other Government on the Index Map; As of December 31, 1997, Treasure Inflation-Protection Securities (TIPS) have been removed from the Aggregate Index. The Tips index is now a component of the Global Real index group.
The current allocation began as of .

Alpha

Alpha is the value added by active management of the portfolio's assets, given the risk of that portfolio. In other words, alpha is equal to the incremental return earned by the manager when the market is flat or stationary. An alpha of zero indicates that the manager earned the exact return dictated by the level of market risk (i.e., beta) of the portfolio. A positive alpha indicates that the manager has earned, on average, more than the portfolio's level of market risk would have dictated. A negative alpha indicates that the manager has earned, on average, less than the portfolio's level of market risk would have dictated. Alpha is the Y-intercept of the least squares regression line.

Beta

Beta is the systematic risk of the portfolio. Measured by the slope of the least squares regression, beta is the measure of portfolio risk which cannot be removed through diversification. Beta is also known as market risk. Beta is a statistical estimate of the average change in the portfolio's performance with a corresponding 1.0 percent change in the risk index. A beta of 1.0 indicates that the portfolio moves, on average, lock step with the risk index. A beta in excess of 1.0 indicates that the portfolio is highly sensitive to movements in the risk index. A beta of 1.5, for example, indicates that the portfolio tends to move 1.5 percent with every 1.0 percent movement in the risk index. A beta of less than 1.0 indicates that the portfolio is not as sensitive to movements in the risk index. A beta of 0.5, for example, indicates that the portfolio moves only 0.5 percent for every 1.0 percent movement in the risk index.

R-Squared

R-squared, or the coefficient of determination, measures the strength of the least squares regression relationship between the portfolio (the dependent variable) and the risk index (the independent variable). The statistic reveals the extent to which the variability in the dependent variable is due to the variability in the independent variable. As such, R-squared measures how well the portfolio returns move in tandem with the returns of the risk benchmark. Though it is true that the higher the R-squared the better, an R-squared of less than 0.9 (i.e., 90 percent), indicates that the total fund does not track closely with the risk benchmark. The strength of the R-squared statistic will reflect on the strength of alpha and beta. A weak R-squared, for example, would indicate that alpha and beta cannot be strictly interpreted.

Brokerage Account

In a brokerage relationship, your Financial Advisor will work with you to facilitate the execution of securities transactions on your behalf. Your Financial Advisor also provides investor education and professional, personalized information about financial products and services in connection with these brokerage services. You can choose how you want to pay for these services and you will receive the same services regardless of which pricing option you choose. There are important differences in your relationship with your Financial Advisor and Morgan Stanley in brokerage accounts and in advisory accounts.

Asset classifications and performance calculation methodologies can differ among the various supplemental performance reports available through us. For example, some reports calculate Time Weighted performance using a weighted or Modified Dietz approach while others use a daily approach. In addition, some reports may display Dollar Weighted Returns. These differences can generate meaningful dispersions in the performance numbers displayed on different reports.

FINANCE COMMITTEE CALENDAR of MEETINGS
FISCAL YEAR 2013–2014

Date:	**Time:**	**Location:**
July 29, 2013	3:00 pm – 4:00 pm	Teleconference *Financial Audit Engagement Letter* *State Hospital Beds*
November 25, 2013	3:00 pm – 4:00 pm	Teleconference *Review of Draft Financial Audit, June 30, 2013* *Review of the first quarter financial statements for the period ending September 30, 2013*
March 24, 2014	3:00 pm – 4:00 pm	Teleconference *Review of the second quarter financial statements for the period ending December 31, 2013*
May 12, 2014	3:00 pm – 4:00 pm	Teleconference *Review of the third quarter financial statements for the period ending March 31, 2014* *Review of Annual Revenue and Expense Report – Proposed Budget, June 30, 2015 for presentation at June 12, 2014 Board of Directors Meeting*

Annual Revenue and Expenditure Report – Proposed Budget

June 30, 2014

- Proposed Budget – June 30, 2014
- Budget Narrative

California Mental Health Services Authority
Annual Revenue and Expenditure Report - Proposed Budget
June 30, 2014

	(B) Actual 6/30/2011	(D) Actual 6/30/2012	(E) Adopted Budget 6/30/2013	(F) Estimated 6/30/2013	(G) Proposed Budget 6/30/2014	(H) Estimated Remaining	Sum of (B) (D) (F) (G) (H) Total	
Unexpended Funds Available from Prior Fiscal Years								
Technical Assist/Capacity Building Unexpended Fund		295,572	-	(119,354)	42,036	-		
MHSA Program Unexpended Funds		83,162,375	109,125,800	110,796,446	86,718,125	30,570,897		
MHSA Community Planning Unexpended Fund		2,742,608	3,869,658	4,520,167	1,265,540	469,290		
WET Program Funds			155,220	155,220	155,220	-		
Interest Income		12,368	358,314	650,419	2,208,148	2,850,148		
Total Unexpended Funds Available from Prior Fiscal Years		**86,212,923**	**113,508,992**	**116,002,898**	**90,389,069**	**33,890,335**	-	
Deposits to CalMHSA Funds during Fiscal Year								
Technical Assist/Capacity Building Funds	339,612	131,000	623,400 (3)	624,111	473,000		1,567,723	
Phase I - PEI Statewide Planning Funds (5%)	4,640,125	2,684,175		11,250	3,750		7,339,300	
Phase I - PEI Statewide Planning Funds (5%) transfer to Program Funds			(2,869,658)	(2,869,658)			(2,869,658)	
Phase I - PEI Planning $ Total							4,469,642	
Phase II - PEI Statewide Program Funds	88,162,375	50,999,325		213,750	71,250		139,446,700	
Phase II - PEI Statewide Program Funds - Additional Funds from Plannin			2,869,658	2,869,658			2,869,658	
Phase II - PEI Statewide Program Funds - Additional Funds from Contingenc							-	
Phase II - PEI Statewide Program Funds							142,316,358	
Project Planning and Development Dues					300,000			
Fiduciary Program Management Wet Program		155,220	-	-			155,220	(4)
Interest Income	12,368	638,051	1,200,000	1,557,729	642,000	95,000	2,945,148	
Total Deposits to CalMHSA	93,154,480	54,607,771	1,823,400	2,406,840	1,490,000	95,000	151,454,091	
Expenditures								
Technical Assist/Capacity Building	44,040	545,926	623,400	462,721	515,036		1,567,723	
Phase I - PEI Statewide Planning (5%) - Expenditures	1,897,517	906,616	500,000	396,219	800,000	469,290	4,469,642	(1)
Phase I - Planning Funds Transfer to Program Funds								
Phase II - PEI Statewide Program - Expenditures		13,371,865	54,100,000	33,928,808	50,062,065	20,000,000	117,362,738	(1)
Phase II - PEI Statewide Program - Expenditures - Transferred from Planning			2,869,658				-	
Phase II - PEI Statewide Program - Expenditures - Transferred from G&A						5,008,950	5,008,950	(1),(5)
Phase II - PEI Program Expenditures			56,969,658				122,371,688	
Evaluation		1,598,475	2,200,000	1,954,062	4,456,413	3,000,000	11,008,950	(1)
WET Program Expenditures			147,720		147,720		147,720	(4)
Project Planning and Development Costs					300,000			
General and Administrative - Wet Program			7,500	-	7,500		7,500	(4)
General and Administrative - PEI		797,122	2,435,000	940,931	2,000,000	2,261,947	6,000,000	(1)
Total Expenditures	1,941,557	17,220,004	62,883,278	37,682,741	58,288,734	30,740,187	145,573,223	
							-	
General and Administrative - PEI Directed to Future Programs			4,416,064				-	
Moved To (From) Operating Reserve	5,000,000	7,597,792	-	(9,662,072)	-		2,935,720	
Total Operating Reserve							2,935,720	(1),(2)
Total Unexpended Funds	86,212,923	116,002,898	48,033,050	90,389,069	33,590,335	3,245,148	2,945,148	

Assumptions:

(1) Sum of these lines is $146,786,000 which is the total of the Phase I and II funding as submitted to MHOAC for the Work Plan ($136,210,400) and Amendment #1 ($8,183,100) pl changes in CalMHSA membership ($2,392,500). Expenditures for 2014 are based on the assumption of expenditures at 100% of total fundi

(2) For the proposed budget as of June 30, 2014 the Operating Reserve has not been budgeted for allocation or expenditure to other categorie

(3) Based on participation indicated for future years as follows

Monterey	68,400
Solano	61,200
Inyo	2,100
Lake	8,900
Los Angeles	300,000
Modoc	1,200
Yolo	31,200
	473,000

Additional counties may participate.

(4) Contra Costa County has contracted with CalMHSA to provide the Fiduciary duties for their program.

(5) $5,008,950 transferred to PEI Statewide Programs from G&A funds based on actual projections of G&A Expenditures through 6/30/15.

-

CalMHSA
General & Administrative Expense - PEI
Fiscal Years 2014 Remaining Estimate

General and Administrative Expenses	2014 Indirect	Remaining
General Management	1,200,000	1,200,000
Other Contract Services	500,000	650,000
Legal Services	100,000	100,000
Financial Audit	15,000	15,000
Insurance	35,000	35,000
Marketing	75,000	75,000
Meetings and other	75,000	186,941
Total General and Administrative Expenses	**2,000,000**	**2,261,941**

CalMHSA Budget Narrative

Background

The CalMHSA June 30, 2014 Annual Revenue and Expenditure Report – Proposed Budget has been developed based on the PEI Statewide Program Funding Request – Budget form – Enclosure F, Appendix 1 of the CalMHSA Statewide Implementation Plan, the addendum to the implementation plan approved by MHSOAC on January 27, 2011, the First Amendment to the CalMHSA Statewide Implementation Work Plan approved on March 23, 2012, and the Plan Update approved on August 9, 2012.

The June 30, 2014 budget presents the current operations of CalMHSA. The current operations presented in this budget are:

- Training/Technical Assistance and Capacity Building
- PEI Statewide Programs – Phase I – PEI Statewide Planning (5%)
- PEI Statewide Programs – Phase II – PEI Statewide Program Implementation
- Workforce Education and Training (WET) – Program Administration
- Project Planning and Development

CalMHSA, at time of approval of the plan, had projected participation of counties. The June 30, 2014 budget continues to be based on these participation projections and projected funding. The summary detail is as follows:

Funding	5% Phase I Planning	71% Program/Direct	9% Contingency Reserve[1]	7.5% Evaluation[2]	7.5% Admin[2]	100% Total
Work Plan Budget	$6,810,520	$97,322,330	$11,645,988	$10,215,780	$10,215,780	$136,210,398
First WP Amendment	$409,155	$5,810,001[3]	$736,479[3]	$613,733	$613,733	$8,183,100
Subtotal	**$7,219,675**	**$103,132,331**	**$12,382,467**	**$10,829,513**	**10,829,513**	**$144,393,498**
Changes in CalMHSA membership	$119,625	$1,698,675[4,7]	$215,325	$179,438	$179,438	$2,392,500
CalMHSA Plan Update	$2,869,658 moved to program/direct →	$2,869,658[5] + $9,662,072[6] = $12,531,730[7]	← $9,662,072 moved to program/direct			
August 9, 2012 Total	4,469,642	117,362,736	2,935,720	11,008,950	11,008,950	146,785,998
August 9, 2013 Percentage	**3.0%**	**80.0%**	**2.0%**	**7.5%**	**7.5%**	**100%**
Transfer of Administrative Funds		5,000,000			(5,000,000) ←	
May 1, 2013 Total	**$4,469,642**	**$120,362,736**	**$2,935,720**	**$11,008,950**	**$6,008,950**	**$146,785,998**
May 1, 2013 Percentage	**3.0%**	**83.4%**	**2.0%**	**7.5%**	**4.1%**	**100%**

1. Originally, the Contingency Reserve was calculated as 9% of the Approved Plan. It is the intent of CalMHSA to maximize the delivery of services. In this Plan Update, $9,662,072 of this reserve will now be utilized for program activities.
2. The maximum allocation permitted by DMH for Indirect Administration services is 15%. Included in this 15% is the requirement to provide evaluation of programs.
3. These dollars differ slightly from those shared during the First Work Plan Amendment; this change is due to the program/direct percentage being calculated as 71%, based on the approved plan.
4. Changes in CalMHSA membership and the assignment of funds by counties and cities resulted in an additional $1,698,675 for program funds.
5. Based on the FY 12-13 CalMHSA Budget approved by the CalMHSA Board on June 14, 2012, planning dollars ($2,869,658) were moved to fund program/direct activities. The new overall percentage of funds dedicated to planning is 3.0%.
6. Contingency reserve dollars ($9,662,072) were moved to fund program/direct activities. The new overall percentage of funds dedicated to the contingency reserve is 2.0%.
7. The total increase in program funds is $14,230,405 (Shift planning and contingency reserve: $12,531,730, plus changes in CalMHSA membership: $1,698,675).
8. $5 million transferred to PEI Statewide Program from General and Administrative funds based on actual projections of General and Administrative expenditures through June 30, 2015.

Budget Notes

1. By June 30, 2014 we anticipate total funds received by CalMHSA are as follows:

Training/Technical Assistance and Capacity Building Funds	$1,567,723
Phase I – PEI Statewide Planning Funds	4,469,642
Phase II – PEI Statewide Program Funds	142,316,358
Workforce Education and Training – Program Administration	155,220
Project Planning and Development	300,000
Interest Earnings	2,850,148
Total funds projected to be received by June 30, 2014	$151,659,091

2. CalMHSA has projected the unexpended funds to be carried over to the Budget of Annual Revenue and Expenditures as of June 30, 2014 to be $33,590,335. See chart on the next page.

Phase I – PEI Statewide Planning Funds	469,290
Phase II – PEI Statewide Planning Funds	30,270,897
Interest Earnings	2,850,147
Total Funds Projected to be Carried to Budget Year Ended June 30, 2014	$33,590,335

3. Deposits to CalMHSA during June 30, 2014 are estimated as:

Training/Technical Assistance and Capacity Building Funds	$473,000
PEI Statewide Planning Funds	3,750
PEI Statewide Program Funds	71,250
Project Planning and Development	300,000
Interest Earnings	$642,000
Total estimated deposits as of June 30, 2014	$1,490,000

4. Expenditures for June 30, 2014 have been estimated based on anticipated payout of the budget approved with the implementation plan:

	Total Approved for PEI Statewide Implementation Work Plan and First Amendment	**Estimated Expenditures June 30, 2013**	**Estimated Expenditures June 30, 2014**	**Remaining**
Training/Technical Assistance and Capacity Building Funds	N/A	$462,721	$515,036	--
Workforce Education and Training Program	N/A	0	155,220	--
Phase I – PEI Statewide Planning Funds	4,469,642	396,219	800,000	469,290
Phase II – PEI Statewide Program Funds	122,371,688	33,928,808	50,062,065	25,008,950
Evaluation	11,008,950	1,954,062	4,456,413	3,000,000
Project Planning and Development Costs			300,000	
General and Administrative	6,000,000	940,931	2,000,000	2,261,947
Subtotal		37,682,741	58,288,734	30,740,187
Contribution to Operating Reserve	2,935,720			
Total	$146,786,000			

5. Project Planning and Development Dues

   At the Strategic Planning Session (SPS) the following action was taken: "Approval of a general funding process for counties to act jointly." The next discussion was regarding the process of which Board members voted on types of additional projects. Subsequently, the board reviewed the historical list of projects and a vote was taken noting a yes, no, and maybe vote. The top three projects with yes votes were State Hospital Beds, Suicide Prevention Program, and Grant Funding (i.e., SAMHSA). It was agreed the actual projects selected would be reviewed again once the funding as determined. The Board then took the following action: "Approval of methodology to select additional projects for counties to act jointly."

   In follow-up to the SPS and the actions above, the Finance Committee discussed the funding of planning and development costs for projects. There was support for funding such approved projects. As such, the Finance Committee discussed how to fund the projects, of which the concept of dues was raised. There was general agreement to use dues solely for the funding of annual planning and development costs related to these projects. Consequently, in order to have board discussion, this budget includes projected planning and development dues and the related planning and development costs of $300,000. The concept, determination of amount, allocation method, and member participation shall be discussed at the Board meeting.

6. CalMHSA will comply with the Department of Health Care Services Guidelines for PEI Statewide Programs in managing and contracting costs for indirect administrative expenses as disclosed on page 3 of the budget package. Some indirect expenses to note are:

   - Legal Expenses – CalMHSA has retained legal services to provide counsel to the board and support of the governing documents. Legal services will decrease for fiscal year ended 2014 due to negotiations of contracts related to execution of the Implementation Plan.

   - Meeting Expenses – CalMHSA is governed by a Board of Directors and has established standing committees and must conduct public meetings to carry out the regular business of the JPA. Conference attendance is also integral to the members maintaining and updating knowledge in Mental Health Services. The JPA currently has 50 members. CalMHSA has provided iPads to distribute the agendas to members electronically. At the last board meeting, only three paper copies of the agenda were distributed.

7. See page 3 of budget package for detail of estimated general administration expenses.

CalMHSA Program Director's Update Report

PEI Statewide Project Implementation Status

Stigma and Discrimination Reduction

Directing Change

High school students throughout California were invited to Direct Change by submitting 60-second videos in two categories: suicide prevention and eliminating stigma about mental illness. A total of 371 submissions were received, representing 922 students and 142 schools from 35 counties. Entries were judged by volunteer experts in mental health and suicide prevention, members of the media, and professionals in filmmaking and video production. Regional winners were selected to move onto a second, statewide round of judging, and narrowed down to the top three entries in each category. Californians were then asked to cast their vote to select the winners who were presented at the screening and award ceremony on May 23rd, 2013 at the Crest Theater in Sacramento. Featured guest speakers included Senate President pro Tempore Darrell Steinberg, along with Director Bradley Buecker from Fox's hit TV series Glee and actor Max Adler, who plays "Dave Karofsky."

For the Suicide Prevention category, Angel Lopez from Loyola High School in Los Angeles County took first place. Second and third places were Tatiana Samano from Los Angeles County and Megan Drew and Lindsay Stevens from San Diego County, respectively.

For the Eliminating Stigma category, Spencer Wilson from Novato High School in Marin County took first place. Second and third places were Emma Spiekerman from Sonoma County and Antonio Pernicano, Adrian Ross, Luis Tagudar, and Kenneth Rizo from San Diego County, respectively.

To view winning PSA's, please click here.

A New State of Mind: Ending the Stigma of Mental Illness

California's mental health leaders and stakeholders were invited to preview "A New State of Mind: Ending the Stigma of Mental Illness," the groundbreaking documentary narrated by Glenn Close. The film, funded by the voter-approved Mental Health Services Act, aims to shatter misconceptions about mental illness through stories of real people who experience hope and resilience in the face of mental health challenges. It also shines a light on the far-reaching effects of stigma related to mental illness. The documentary aired on public television stations all across the state on local and regional stations on May 30th, and is now hosted on www.EachMindMatters.org, along with a gallery of vignettes featuring additional stories. The documentary was produced as a part of a comprehensive statewide effort to increase the number of people who seek help for mental challenges by reducing stigma and discrimination associated with mental illness.

Each Mind Matters – California's Mental Health Movement

Coinciding with Mental Health Month, CalMHSA launched www.EachMindMatters.org to give every Californian the tools to combat stigma and build mental health awareness. Following the momentum of "A New State of Mind," a few key next steps are being made a priority:

- Spanish-language testing to determine precise translation of Each Mind Matters.
- Style guide and various iterations of Each Mind Matters for different mediums developed.
- Resource materials produced and distributed to PEI network.
- Developing capacity to expand support for adaptations of Each Mind Matters to a variety of networks—education, law enforcement, healthcare, etc.

An additional resource, www.SpeakOurMinds.org was also launched to be an online tool for millions of Californians coming together to fight stigma and promote awareness, compassion, and acceptance. Speak Our Minds makes it easy for community organizations interested in hosting speakers bureaus regarding stigma and discrimination reduction. An initial amount of $191,000 was distributed to organizations statewide to start or build a speakers bureau featuring CalMHSA's messages. A second round of applications is underway, and was due on May 24th. The funds will be awarded on June 28, 2013.

Furthermore, Community Dialogue Events are being held throughout the state. These events feature explorations of stigma in attendees' lives and communities, and grants of up to $30,000 will be awarded to small and rural community-based organizations. The awards will be announced in June 2013.

California Innovations Summit: The Triple Aim as a Framework for Improving the Health of Individuals with Complex Mental Health, Substance Use, and Physical Health Conditions

On May 22–23, 2013, the CalMHSA Integrated Behavioral Health Project and the California Institute for Mental Health co-sponsored the *California Innovations Summit: The Triple Aim as a Framework for Improving the Health of Individuals with Complex Mental Health, Substance Use, and Physical Health Conditions*. Additional co-sponsors included the California Primary Care Association, Kaiser Permanente, the County Alcohol and Drug Program Administrators of California, the California Mental Health Directors Association, and the Alcohol and Drug Policy Institute.

The goal of the Summit was to support achievement of the Triple Aim for complex clients with mental health, substance use, and co-occurring medical conditions by sharing innovative care coordination and integration models currently being implemented in California. The Summit included action and strategy development through facilitated dialogues focused on core requirements for system redesign on such topics as:

- Promoting Health Literacy, Healthy Behaviors, and Self-Management
- Incentivizing Integrated Care, Payment Reform, and Quality Improvement
- Designing Prevention and Health Promotion to Improve Population Health

Over 240 participants attended, representing the range of stakeholders interested in integrated care and health reform, including county departments of mental health and public health, mental health and substance use agencies and providers, primary care clinics, health plans, consumers and family members, peer specialists, and social service agencies. Numerous counties—San Francisco, Napa, Glenn, San Mateo, Los Angeles, Alameda, and Riverside—presented on key practice strategies and systems changes that can be replicated in other counties and programs. The CalMHSA Integrated Behavioral Health Project, in collaboration with CiMH, will publish conference proceedings documenting recommendations and action plans to inform State and local policy and practice. These findings will be disseminated on the IBHP Website (www.ibhp.org) and the CiMH Website, and presented at briefings to DHCS, California Health Foundations, and others interested in Summit outcomes. For additional information, please contact Karen Linkins, IBHP Project Director (karen@desertvistaconsulting.com) or Jennifer Clancy (jclancy@cimh.org).

Suicide Prevention

California Suicide Prevention Network Program

- Crisis centers are partnering to improve and standardize data collection among callers to suicide prevention hotlines, in order to understand the reach and impact of crisis center services. Data collection on this program began on June 1, 2013 and will continue through fiscal year 2013-14.
- Didi Hirsch Mental Health Services is partnering with stakeholders (counties, crisis centers, individuals participating in the regional task force meetings, etc.) around the state to develop best practices in each region. Data has been reviewed and priority topics are being selected. Best Practice committees are being formed in each region; for more information or to get involved, please contact Lyn Morris at 310-895-2305 or LMorris@didihirsch.org.

Regional Crisis Center Capacity Building

Crisis centers are increasing access to Californians by offering services in additional languages and through online and mobile services. Program investments include training, technology (e.g., improving data collection), improved practices and adherence to standards (e.g., accreditation). In addition, crisis centers are utilizing innovative approaches to recruit and retain qualified volunteers, thereby enhancing the sustainability of hotline services. Recent examples include:

- The Kern County Mental Health Crisis Hotline combines volunteer recruitment at the local college and university with on-campus education about local mental health and suicide prevention resources. Pairing recruitment and suicide prevention gatekeeper training such as Question, Persuade, Refer (QPR) enables the hotline to increase community knowledge about suicide, prevention, and local resources. In the past quarter, their team trained over 100 participants in ASIST and over 500 participants in QPR.

- The Family Service Agency of the Central Coast is implementing its second iteration of the Assistant Trainer program. Assistant Trainers are experienced hotline responders who receive special training and supervision to assist in the training, evaluation, and orientation of new volunteer responders. This strategy enhances the skills of existing volunteers and creates a supportive environment for new volunteers.

Suicide Prevention Training

LivingWorks—together with their partner organizations Didi Hirsch, WellSpace Health (The Effort) and Contra Costa Crisis Center—are planning for an expansion of ASIST and safeTALK training for trainers during the remainder of the CalMHSA contract. This expansion is an effort to address the training needs of CalMHSA counties. In addition, for those already trained as ASIST trainers, a statewide strategy to upgrade trainers to the new ASIST curricula, ASIST 11, is being developed. Regional upgrade sessions will be held between July 1, 2013 and December 31, 2014. If you are interested in hosting an upgrading session in your area, please contact Jerry Swanner at jerry.swanner@livingworks.net.

Student Mental Health

In the quarterly reports submitted by Student Mental Health (SMH) program partners, CalMHSA is beginning to see the scope and impact across California education systems from kindergarten through higher education. Systemic capacity is building and this is evident from the number of students, staff, faculty and parents being reached with training, information, and resources. While, there is still a ways to go in developing new and stronger relationships that reach across systems, the beginning of this is evident. All educational partners are indicating a reach that includes contact with County Mental Health staff and often includes collaboration with counties on activities. SMH uses resources of the SP and SDR program partners in many activities. The recent SP/SDR Student public service announcement (PSA) contest success shows the value of the relationships between systems.

Higher Education

CSU – All 23 campuses are busy with a multitude of activities. Impact data to date shows:

- 54,546 students, faculty and staff were reached in fiscal year 2012-2013 through presentation, trainings, tabling, and campus-wide events.
- 37,956 students accessed Student Health 101, the online health magazine which features stories of improving student mental health (this magazine is also available to parents of CSU students).
- 1,899 students, faculty, staff and community-based partners received training in SP and SDR. All campuses have certified trainers in QPR, ASIST, MHFA or Kognito who are providing SP and SDR training to the campus community.

UC – All 10 campuses are active, data from the **January** through **March** shows:

- 91 staff and faculty trainings reaching more than 2,100 staff and faculty were conducted and included topics such as QPR, Assisting Students in Distress, and What Every Faculty Need to know.
- 533 graduate teacher/research assistants attended trainings.
- 347 student trainings were conducted by counseling and psychology staff and more than 8,328 students attended these various trainings on topics such as social justice and multiculturalism, and Mental Health Wellness and Coping.
- Peer education programs on campuses were enhanced and expanded by outreach from Counseling and Psychology, impacting more than 2,418 students through leadership programs focused on well-being and mental wellness.
- Routine protocol for students attending an initial counseling appointment or for emergency services, including suicide screening. To date, 25,926 students have been screened. Additional depression screenings to date on each UC campus have surpassed the target of screening 5% of the student population.

CCC – 30 campuses are implementing campus based grants. Campus profiles can be found at www.cccstudentmentalhealth.org. Other system-wide activities include:

- Kognito Suicide Prevention Training has been implemented on 54 campuses with the following number of participants trained to date (all 112 campuses will receive training by June 2014):
    - 1,917 staff and faculty
    - 1,783 student leaders
    - 624 student veterans
- Welcome Home Veterans on Campus Trainings have taken place on the Fresno City, Las Positas, Santa Monica and San Mateo campuses. Trainings are planned for the Chabot (8/16), Cabrillo (8/30), Southwestern (9/20) and Cuesta (9/27) campuses.
- 7,298 individuals participated in a grant related activities.

Active Minds/Send Silence Packing is coming to California Campuses in the Fall

Send Silence Packing is an exhibit of 1,100 backpacks representing the number of college student lives lost to suicide each year. Active Minds Inc. has collected and continues to collect backpacks and personal stories in memory or in honor of loved ones impacted by suicide. By displaying backpacks with personal stories of loved ones that put a "face" to lives lost to suicide, *Send Silence Packing* carries the message that preventing suicide is not just about lowering statistics, but also about saving the lives of students, daughters, sons, brothers, sisters and friends across the nation. Contributions serve as a meaningful outlet for survivors' grief as well as a powerful way to raise awareness and work towards suicide prevention.

FALL 2013 TOUR

September 10 | Riverside City College
September 12 | Palomar College
September 17 | Santiago Canyon College
September 19 | CSU Fullerton
September 24 | CSU San Bernardino
September 27 | California Polytechnic State University
September 30 | Porterville College
October 2 | Fresno City College
October 8 | West Valley College
October 11 | Sacramento, CA (city display)
October 15 | Santa Rosa Junior College
October 18 | San Francisco State University

CCSESA K-12

On May 29th, CCSESA presented program data to the CalMHSA Statewide Evaluation Expert (SEE) Team. The SEE Team expressed great interest in the comprehensiveness and methods for data collection that will be used by RAND in the evaluation of CCSESA SMHI Project. Of important note is that trainings funded by CalMHSA are being evaluated as part of the RAND evaluation. Due to the language needs of those attending trainings, the surveys are available in English, Spanish and Chinese and are soon to be translated into Korean, Vietnamese and Farsi. Highlights of the CCSESA impact from January through March 2013 is:

- 61 demonstration programs are being implemented in 11 regions throughout California, reaching the following individuals:
  - 4,292 adults
  - 34,555 students
  - 309,000 students (estimated reach)
- 2,186 individuals participate in regional cross-system collaboratives
- 1,988 have visited the Website clearinghouse: www.regionalk12smhi.org
- 6,953 individuals participated in trainings

Training/Technical Assistance and Capacity Building

A cohort of counties is continuing to fund the Training, Technical Assistance and Capacity Building (TTACB) program in FY 2012-13 and 2013-14 in order to receive technical assistance from the RAND/SRI team, and participate in regional evaluation activities. Based on recommendations from

counties, Phase II activities are underway: continued provision of technical assistance to counties and regional data workgroup meetings.

RAND is currently modifying content from recent webinars and regional data workgroups so that it can be accessed online. The *Getting to Outcomes* webinars are being recorded and will be edited and provided as an online resource for later viewing. RAND will also provide an overview of key materials from the **Making the Value Case for PEI Funding** workgroup in a webinar format that will be posted for later viewing. In addition, based on feedback from counties that participated in the work groups, RAND is developing and testing tools to comprehensively describe county level PEI programs and support collection, analysis and reporting on PEI outcomes. These tools will be provided at no cost to counties that wish to use them.

RAND is also developing plans and materials for a work group series focusing on specific evaluation approaches and methods for different kinds of PEI programs. These work groups are expected to begin in August and September 2013.

Please contact Sarah Brichler at 916-859-4827 or sarah.brichler@calmhsa.org with any questions.

Evaluation

Statewide Evaluation Experts (SEE) Team

Wednesday, May 29th marked the most recent meeting of the SEE Team. The meeting, which took place in Sacramento at CiMH, focused on reviewing the additional evaluation activities from the RAND Corporation in order to meet the works of Program Partners who are expanding cultural competencies and increasing impact to geographic regions across the state.

Highlighted in this meeting was what is being learned by Program Partners from their own evaluations:

- Runyon, Saltzman and Einhorn, Inc. demonstrated how their research is driving campaign activities. To see their presentation, click here: http://calmhsa.org/wp-content/uploads/2013/06/SEE-Presentation-May-2013.pdf.
- Didi Hirsch has coordinated the ground-breaking effort of collaborating 10 crisis centers, located in different regions throughout the state, to create a set of common metrics. This effort standardizes the measurement process for engagement and efficacy of the participating call centers, and provides feedback for Program Partners and call center volunteers. To see their presentation, click here: http://calmhsa.org/wp-content/uploads/2013/06/Didi-Hirsch-Presentation.pdf
- CCSESA presented information on their online clearinghouse, as well as preliminary numbers on the reach and impacts of their trainings and outreach efforts. This included population demographics as well as an introduction to the evaluation efforts that are currently being completed. To see their presentation, click here: http://calmhsa.org/wp-content/uploads/2013/06/CCSESA-Presentation.pdf

The SEE Team meets again on Thursday, August 29, 2013, to review the first draft of RAND's statewide evaluation project. The meeting will be at the RAND office in Santa Monica, California.

Conquering mental illness:
Monica Potts' Skid Row success story

Posted May 28, 2013 by Lisa Napoli

For decades, Monica Potts called a tent on the corner of 5th and Crocker on Skid Row home. Today, she works across the street, at a place called LAMP, where she counsels others to help get off the street.
How did this nearly 50 year old woman finally conquer mental illness, drug addiction, and homelessness? Force of will, medication, and counseling, she says — lots of counseling.

This is where Monica Potts used to sleep, at the corner of 5th and Crocker Streets on Skid Row downtown

"I was disconnected and distorted, and that drove me to the substance I was using, but after being in a healthy setting, and having someone give me a different view, I started to look at things a little differently," she told me. "Some of my esteem returned. I was more motivated to try something new."

And now, after 8 years sober, getting married, and moving into a stable home, she's excited about her work helping others on Skid Row make the same leap.

I talked to her in her office and then across the street from it, at the corner she used to call home. Here's our conversation:

Mental-health documentary features Tulare County segment

Written by Staff and wire reports

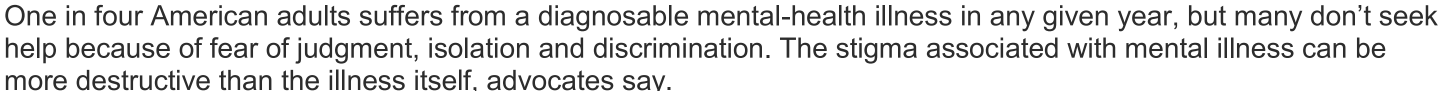
A mental-health documentary narrated by actress Glenn Close and featuring Tulare County mental-health care advocate Lali Moheno will be screened at 8 p.m. today on Valley PBS. (Comcast Cable Channel 8, Broadcast Channel 18)

"A New State of Mind: Ending the Stigma of Mental Illness" tells the stories of everyday people across California to shatter myths about mental illness and highlights the struggles faced by those with mental-health challenges, as well as their hope for recovery and resilience.

Moheno's segment focuses on farmworkers. It was filmed in late March around Lindsay, Woodville and Poplar.

Moheno hasn't gotten a chance to see the documentary yet, so she'll be watching it tonight for the first time with the general public.

"I'm excited. I think getting as much information about mental illness as possible is always a good thing," Moheno said.



One in four American adults suffers from a diagnosable mental-health illness in any given year, but many don't seek help because of fear of judgment, isolation and discrimination. The stigma associated with mental illness can be more destructive than the illness itself, advocates say.

Close is a mental-health advocate and founder of an anti-stigma campaign, Bring Change 2 Mind.

The documentary is produced by KVIE, Sacramento's PBS station. It will be broadcast statewide.

Elyn Saks, associate dean of the USC Gould School of Law, former U.S. Rep. Patrick Kennedy and two-time Olympic gold medalist diver Greg Louganis are among the many subjects profiled in the hour-long documentary.

The premiere of the documentary coincides with this month's launch of California's mental-health movement, Each Mind Matters. Each Mind Matters unifies the hundreds of organizations working together to create health systems that service minds and bodies, and the millions of Californians who refuse to stay silent while untreated mental illness takes an unnecessary toll on our families and communities.

How to watch

"A New State of Mind: Ending the Stigma of Mental Illness" will be air at 8 p.m. today on Valley PBS. (Comcast Cable Channel 8, Broadcast Channel 1)

To learn more about "A New State of Mind: Ending the Stigma of Mental Illness" and California's mental-health movement, visit*EachMindMatters.org*.

Orange County Patients Overcome Mental Illness Stigma in PBS Documentary Tonight

By OC Weekly Contributor Thu. May 30 2013 at 7:13 AM

Tonight at 10PM, PBS will broadcast A New State of Mind: Ending the Stigma of Mental Illness, narrated by Academy Award-nominated actress and mental health advocate Glenn Close. Both Close's sister and nephew are coping with mental health challenges, like one in every four Americans.

Surprisingly, the documentary is upbeat and shows Californians living full lives despite mental illness. The film's goal is to reduce the stigma associated with mental illness and get more people to come in for treatment.

With support and treatment, from 70 to 90 percent of people diagnosed with a mental illness can have a significant reduction in symptoms and improved quality of life. Unfortunately, two-thirds of Californians who have access to psychological care don't get it. For many the reason is stigma. As participant Monica Potts put it, her parents didn't discuss mental illness but said, 'What's wrong with you, girl?'

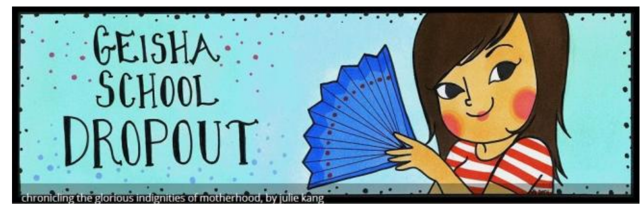
A New State of Mind features Orange County residents Greg Louganis and Clayton Chau. Dr. Chau, a Santa Ana psychiatrist, discusses his own experience with trauma and mental illness. Born in Vietnam, he escaped by boat to a refugee camp in Malaysia, where he was a victim of abuse. He started having nightmares in medical school, but learned to cope with his mental health challenges and use his experiences to help his community and educate doctors.

Greg Louganis, Olympic diver and star of ABC's Splash, attended Mission Viejo High School and UC Irvine. He won four gold medals at the 1984 and 1988 Olympic Games on the springboard and platform. In 1988, he won in an inspiring display of courage after suffering a concussion.

Yet despite his accolades, Louganis reveals years of battling with abuse, bullying and clinical depression, including several suicide attempts. "When I grew up you didn't talk about mental health or depression or anything like that."

After treatment and medication, he now uses yoga and meditation to cope. Former Congressman Patrick Kennedy speaks frankly about his own bipolar disorder. But he also talks about how his father, Ted Kennedy, saw his brothers violently killed. He suffered post stress disorder, "but we didn't give it a name then."

For both Kennedy and Louganis, speaking about their own issues is a key to fighting stigma. The film and website provide links to mental health resources. A New State of Mind also takes a fascinating look at how people in minority communities, from Mexican-American field workers to Laotian Hmong refugees to Native Americans, are using innovative methods like gardening and traditional Indian dance to address mental illness.



A New State Of Mind

A NEW STATE OF MIND: ENDING THE STIGMA OF MENTAL ILLNESS
May 30 on PBS Visit EachMindMatters.org

Last week, I had the honor of attending a screening for a new documentary called "A New State of Mind: Ending the Stigma of Mental Illness" at PBS SoCal's studios. It was produced by KVIE, the PBS station in Sacramento, and narrated by Glenn Close.

Words cannot properly describe how informative and inspirational it was to see my fellow native Californians, some famous and some not famous (yet), bravely talk about their struggles with and triumphs over their various illnesses. There were representatives from a variety of ethnicities, backgrounds, and diagnoses, including a wonderful profile on a Vietnamese man who learned how to acknowledge and eventually overcome his PTSD from a war-torn and refugee childhood, while attending medical school, and subsequently becoming a psychiatrist with the special ability to empathize with his patients' suffering.

The documentary will be aired state-wide this Thursday, May 30th, and you can check their website for the air time in your area. Also, once it airs, it will be made available online so people everywhere can watch. In the meantime, here is an extended preview, featuring Olympic gold medalist Greg Louganis:

After the screening, Melissa Nemeth from NAMI Orange County and Monica Potts from LAMP Community spoke about their experiences and advocacy work

Another synopsis of the event can be found here, including a link to more pictures.

Also, all this week I will talk more about my personal struggles with mental illness in order to commemorate the launch of this documentary and for Mental Health Awareness Month in general.

Among my fellow audience members was Ron Thomas, father of Kelly Thomas, an unfortunate victim of the stigma against mental illness.

For Immediate Release
June 3, 2013
California Mental Health Services Authority
TEAM Up
National Association of Broadcasters
Entertainment Industries Council, Inc.
CONTACT: Mike Roth: 916-444-7170

Following President Obama's Mental Health Summit, California Spotlights Efforts to bring Mental Illness "Out of the Shadows"

California's pioneering efforts to eradicate stigma and expand early mental health services made possible through voter-approved Proposition 63

The President's National Mental Health Conference is being streamed live until 11:45am PT at whitehouse.gov/live.

SACRAMENTO, CA -- Today, President Obama challenged America to bring mental illness "out of the shadows," so that more people can seek help that will enable them to live full lives. Following this announcement, the California Mental Health Services Authority (CalMHSA) which is spearheading statewide efforts to eradicate stigma and expand early mental health services, and its partners, including Entertainment Industries Council, Inc. and the National Association of Broadcasters, offer a wealth of expertise, data, and resources to journalists.

California is leading the nation in innovative strategies that shatter misconceptions about mental illness, otherwise known as "stigma," a factor the U.S. Surgeon General has called the "most formidable obstacle" to improving the nation's mental health. One in four American adults suffers from a diagnosable mental health illness in any given year, but many don't seek help because of fear of judgment, isolation and discrimination. California's stigma reduction campaign aims to connect more people with help early on, when outcomes are better, quality of life is improved, and treatment costs are reduced.

Stigma Reduction Resources & Experts Available for Comment:

1) Mental Health Media Style Guide and Toolkit
Research shows many media portrayals of mental illness are inaccurate, unbalanced and can even perpetuate suicide through sensationalizing the act. To improve accuracy of reporting and media depictions, CalMHSA's TEAM Up Tools for Entertainment and Media initiative developed English and Spanish-language resources for creative writers and journalists expected to be announced at the White House National Mental Health Conference today. The toolkit and additional resources including tips on interviewing people living with mental illness, story ideas and entertainment depiction suggestions are available at http://www.eiconline.org/teamup/. Contact: Skylar Jackson at sjackson@eiconline.org.

2) A New State of Mind: Ending the Stigma of Mental Illness
This groundbreaking documentary narrated by Glenn Close aired statewide on PBS stations Thursday, May 30, 2013 and is available at www.eachmindmatters.org. Through the stories of real Californians, the film shatters myths about mental illness, highlighting the struggles faced by those with mental health challenges, and their hope, resilience and recovery. Contact: Scott Rose at SRose@rs-e.com.

3) EachMindMatters.org
Each Mind Matters is the online home to California's mental health movement, empowering each Californian with the tools to get informed about mental illness, take concrete steps to eradicate stigma, and connect with the resources to help a loved one in crisis. Contact: Scott Rose at SRose@rs-e.com.

4) ReachOut Forums
The English- and Spanish-language forums at ReachOutHere.com and BuscaApoyo.org link 14-24 year old Californians to tools, resources and a series of interactive message boards. While mobilizing youth to change social norms, the forums provide visitors with a safe space to discuss a range of social and mental health related issues with trained peer leaders and encourage both support seeking and support giving around mental health challenges. Contact: Scott Rose at SRose@rs-e.com.

5) California Mental Health Leaders
"We are beginning to make strides on mental health, but we must continue to educate our friends, families, and colleagues on this critical issue and eliminate stigma to let those suffering know that it is always okay to seek help," U.S Representative Grace Napolitano, (D-CA) said. "As part of May Mental Health Awareness Month and throughout the year, I have worked with my

colleagues to host congressional briefings on children's mental health, veterans' mental health, and suicide prevention. I have also supported and sponsored legislation to better address the mental health needs of adolescents, children, minorities, and seniors. The collective power of communication and media engagement continues to be crucial to building a better understanding that mental illness is like any other illness and needs to be discussed and treated; TEAM Up can provide this necessary change. These Spanish language news media resources will have a strong positive effect in Latino communities in California and across the nation," she continued.

"One in four U.S. adults experiences a mental health disorder in a given year, while only 25 percent of those people will get the help they need. President Obama's focus on the critical issue of breaking down mental health stigma is a game-changer, and California's Senate is already seizing the momentum he has created to increase the number of people who can and do access live-saving services in this year's budget discussions. California's programs are a model for the nation in bringing mental health resources to underserved and diverse communities and empowering everyone in our state to stand together to ensure Each Mind Matters," Senate President Pro Tem and Prop. 63 author Darrell Steinberg.

"I applaud President Obama for putting a much-needed focus on improving access to mental health resources. The facts are clear: Prevention and Early Intervention programs make a life-saving difference—giving teens and families the tools to reduce suicide, breaking down social and cultural barriers that deter people from getting help, and connecting young people with resources to help with the most challenging time in their lives," commented Dr. Wayne Clark, president, California Mental Health Services Authority.

# # #

TEAM Up, A New State of Mind, and Each Mind Matters are funded by the voter-approved Mental Health Services Act (Prop. 63). These Stigma and Discrimination Reduction programs are three of the Prevention and Early Intervention Initiatives implemented by the California Mental Health Services Authority (CalMHSA), an organization of county governments working together to improve mental health outcomes for individuals, families and communities. CalMHSA operates services and education programs on a statewide, regional and local basis.

California Mental Health Services Authority
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Rancho Cordova, CA 95670
Office: 916.859.4800
Fax: 916.859.4805
www.calmhsa.org

Open Solicitation for Applications for One Stakeholder Member of the CalMHSA Program Advisory Committee

July 13, 2012

The California Mental Health Services Authority (CalMHSA) is seeking one qualified Stakeholder to serve on the CalMHSA Program Advisory Committee for a 2 year term. The Program Advisory Committee serves as an advisory body to the CalMHSA Board and/or Executive committee.

The California Mental Health Services Authority (CalMHSA) is an Independent Administrative and Fiscal Governments Agency focused on the efficient delivery of California Mental Health Projects. Member counties jointly develop, fund, and implement mental health services, projects, and educational programs at the state, regional, and local levels.

CalMHSA is not a legislative agency, nor are we an approval or advocacy body. We are a best practice inter-governmental structure with growing capacity and capability to promote systems and services arising from a shared member commitment to community mental health. CalMHSA supports the values of the *California Mental Health Services Act:*

- Community collaboration
- Cultural competence
- Client/family-driven mental health system for children, transition age youth, adults, older adults
- Family-driven system of care for children and youth
- Wellness focus, including recovery and resilience
- Integrated mental health system service experiences and interactions

CalMHSA seeks to fill one vacant Stakeholder Committee Member position. CalMHSA seeks candidates who represent one or more of the following priority areas:

- Bay Area
- Underserved Communities
- Native Americans
- Older Adults
- Health/Mental Health Background
- Consumer/family

Potential applicants are encouraged to review the following documents prior to submitting an application.

- California Mental Health Services Authority Program Advisory Committee Proposal
- Advisory Committee Conflict of Interest Policy

For questions or for consideration for membership on the Program Advisory Committee, please complete and return the attached application, along with your resume and the Non-Conflict of Interest form by Friday, August 10, 2012, to Laura Li at laura.li@georgehills.com, in an electronic format.

Sincerely,

Ann Collentine, MPPA
Program Director

California Mental Health Services Authority
Program Advisory Committee Proposal

Adopted on August 11, 2011

Advisory Committee Proposal

This document describes the proposed structure for creating a new committee of CalMHSA called the Program Advisory Committee. The conceptual framework for the Advisory Committee was developed based on stakeholder feedback received at the July 14, 2011 CalMHSA Board meeting, Board discussion and an informal stakeholder meeting held on July 27, 2011.

Overview of Advisory Committee

Structure/Membership

- Advisory Committee to the CalMHSA Executive Committee and/or Board
- Membership consists of 12 members: 6 standing members of the Board of Directors (1 member of the Executive Committee and 5 representing CA regions), and 6 stakeholder members (Co-chair and 5 representing CA regions)
- Committee members serve two-year terms
- Advisory Committee (AC) to be co-chaired by one Board Member and one stakeholder
- A committee subject to the Ralph M. Brown Act, open to public participation

Purpose

- Serves as a hub of communication and disseminates all program information to stakeholders, partners, Board of Directors, etc.
- Has Board advisory authority for:
  - Ongoing oversight of regular reporting from Program Partners in key areas related to Core Principles adopted by CalMHSA
  - Development and administration of a system for compiling, analyzing and reporting stakeholder feedback on the statewide PEI and other programs
  - Ongoing oversight related to new programs or structures to be created, including program monitoring, compliance, and reporting of results
  - Provide input on member services and expansion of CalMHSA services

Decision Making

- Advisory only
- Adopts decisions by consensus
- When consensus not possible, opposing positions are reported to the Board as a report from the committee

Meeting Commitment(s)

- First meeting will be in person and include a discussion of proposed meeting schedule
- Includes a budget for travel/stipend

Stakeholder Membership Application and Selection Process

- Application process is consistent with the existing process for selecting SME/SEE panel members. Optional webinar on how to submit an application for membership and expectation of committee members.
- Application process is open to any stakeholder recognizing when there is a conflict of interest that member must recuse him/herself

- CalMHSA is to have a selection committee (to include stakeholder representation) which is responsible for reviewing applications, conducting interviews and selecting candidates
- Criteria for selecting the six stakeholder members requires that:
  - Stakeholder occupies a position of influence and is empowered to speak for his/her organization
  - Stakeholder contributes to diverse representation of consumers and families, cultural groups, and age spans and geographic regions

Expectations for Stakeholder Members

- Members serve in person (no alternates)
- Members are prepared for and participate regularly in CalMHSA meetings, teleconference calls, etc. as appropriate
- Members develop a clear understanding of the CalMHSA organization
- Members will be provided training to ensure a clear understanding of CalMHSA mission

Estimated Time Frame

- August 2011 - Present proposal to the Board of Directors
- August/September 2011 - Stakeholder application process open for 30 days
- September 2011 - CalMHSA Selection Committee reviews and selects stakeholder members
- October 2011 - First meeting of the Advisory Committee

ADVISORY COMMITTEE
CONFLICT OF INTEREST POLICY

Committee members who have a conflict of interest concerning a Program Partner should recuse themselves from discussions or votes that specifically concern or may affect that Program Partner.

DEFINITIONS

1. "Conflict of interest." A committee member has a conflict of interest if the person, the person's spouse, the person's dependent child, or the person's resident relative has an "economic interest" in or "disqualifying relationship" with a "Program Partner;" and

    a. It is foreseeable that the decision will have a material effect on the "economic interest" of the person (or the person's spouse or dependent child or resident relative) which is distinguishable from its effect on the public generally, or

    b. It is foreseeable that the decision will have a material effect on the "economic interest" of a "Program Partner" with whom the person (or the person's spouse or dependent child or resident relative) has a significant relationship.

2. "Disqualifying relationship" means the position of officer, director, employee or volunteer, regardless of whether the position is compensated.

3. "Economic interest" means any fee, money, or financial gain, or other valuable benefit received directly or indirectly from or by reason of any dealings with or service for CalMHSA. "Economic interest" includes, but is not limited to, investments, business positions, interests in real property, services, and reportable sources of income.

5. "Program Partner" means a person or organization that provides goods or services to CalMHSA, and includes but is not limited to those contractors performing statewide PEI projects.

6. "Subcontractor" means a subcontractor of a Program Partner on a CalMHSA contract.

CONFLICT OF INTEREST STATEMENT

I acknowledge that I have been appointed as a member of an Advisory Committee that may be involved in hearing, discussing and adopting recommendations to CalMHSA's Board that could affect a Program Partner or Subcontractor.

I understand that persons making recommendations or giving advice to CalMHSA's Board must be free of any real or perceived conflict of interest. For purposes of this Statement, I understand that a conflict of interest exists whenever I have any relationship with a Program Partner or Subcontractor that could interfere with my ability to exercise objectivity in the evaluation process.

Circumstances that may create a real or perceived conflict of interest include, but are not limited to, the following situations in which I:

1. Have a monetary or personal interest in the award, amendment, revision, or evaluation of a contract with a Program Partner.
2. Am employed or have been employed by a Program Partner or have a close relative (spouse, parent, child, or sibling) who is so employed by the Program Partner or Subcontractor.
3. Am an officer, director, or volunteer for a Program Partner or Subcontractor.
4. Am employed or have been employed by a Subcontractor or have a close relative (spouse, parent, child, or sibling) who is so employed by the Subcontractor.
5. Am or have been a consultant to the Program Partner or a Subcontractor.
6. Am or have been a student, intern, trainee, volunteer or any other non-paid staff placed at a program of the Program Partner or a Subcontractor.
7. Am currently receiving or have previously received services from a Program Partner or a Subcontractor.
8. Have a spouse, parent, child, or sibling who is currently receiving or who has previously received services from a Program Partner or a Subcontractor.
9. Have been directly or indirectly involved in preparing the proposal of a Program Partner or Subcontractor in response to a Request for Proposals from CalMHSA.

RECUSAL PROCEDURE

If an item of business on the agenda for an Advisory Committee meeting involves or seems likely to affect a Program Partner or Subcontractor with which the committee member has a conflict of interest, at the commencement of discussion on that item the committee member shall announce that he or she has a possible conflict and will not participate in the discussion or voting on that agenda item. After making this announcement, the committee member may remain in the room but may not comment or vote on the item. The recusal shall be recorded in the minutes.

AFFIRMATION

After due consideration and review of the above,

1. I have listed below any and all Program Partners and/or Subcontractors in which I have an economic interest or disqualifying relationship.

2. I affirm that during the time I serve on the Advisory Committee, I will immediately disclose any new economic interests in or disqualifying relationships with Program Partners and/or Subcontractors.

3. I affirm that I will comply with the Recusal Procedure stated above.

4. I further agree to give written notice to either or both of the Co-Chairs if at any time my personal, financial, or fiduciary relationship to one of the Program Partners or

Subcontractors precludes me from rendering render fair and impartial service free of bias.

Print: ____
Print Your Name Title

Sign: ____
Signature Date

List of Program Partners/Subcontractors

Suicide Prevention – Approved Programs

Program			Provider
1	Suicide Prevention Network Program		Didi Hirsch Community Mental Health Services
2	Regional Local Suicide Prevention Capacity Building Program		
	A	Ventura, San Bernardino, Riverside, Orange, San Diego, Imperial & Los Angeles	Didi Hirsch Community Mental Health Services
	B	San Luis Obispo, Santa Barbara & Kern	Transitions Mental Health Association
	C	Monterey & Santa Cruz	Family Services Agency of the Central Coast
	D	Marin, Sonoma, Napa, Lake, Mendocino & Solano	Family Services Agency of Marin
	E	San Francisco, Santa Clara, San Mateo & Contra Costa	San Francisco Suicide Prevention
	F	Sacramento, El Dorado, Placer, Yolo, Sutter/Yuba, Amador, Butte, Colusa, Glenn, Trinity, Humboldt, Siskiyou , Tuolumne, Calaveras & Modoc	Institute on Aging Center
	G	Fresno, Madera, Merced & Stanislaus	Kings View
3	Social Marketing		AdEase
4	Suicide Prevention Training Workforce Enhancement Program		LivingWorks

Stigma & Discrimination Reduction (SDR) Approved Programs

Program			Provider
1	Strategies for a Supportive Environment Program		
	1	Stigma Discrimination Consortium	TBD
	2	Social Marketing	Runyon, Saltzman & Einhorn
	3	Capacity Building	United Advocates for Children & Families
2	Values, Practices and Policies Program		
	1	Resource Development	Mental Health Association of San Francisco
	2	Partnering with Media and the Entertainment Industry	Entertainment Industries Council, Inc
	3	Promoting Integrated Health	Community Clinics Initiative
	4	Promoting Mental Health in the Workplace	*No proposals submitted for this component*
	5	Reducing Stigma and Discrimination in Mental Health and System Partners	National Alliance on Mental Health
3	Promising Practices Program		Mental Health Association of San Francisco
4	Advancing Policy to Eliminate Discrimination Program		Disability Rights California

Student Mental Health – Approved Programs

Program	Provider
California State University	California State University Office of the Chancellor
California Community Colleges	California Community Colleges Office of the Chancellor
University of California	Regents of the University of California
Statewide K-12	California Department of Education
Regional K-12	California County Superintendents Educational Services Association

STIGMA & DISCRIMINATION REDUCTION CONSORTIUM STRATEGIC WORK PLAN

October 11, 2012

SDR Consortium Members

Name	Affiliation
Brianda Alanis	Inspire USA Foundation
Kirsten Barlow	CA Mental Health Directors Association
Adrian Bernard	Second Story Peer-Run Respite, NAMI
Rocco Cheng	Pacific Clinics
Shawn Davis	Youth in Mind
Azizza Davis Goines	Sacramento Black Chamber of Commerce
Kathleen Derby	NAMI California
Andrew Duch	Butte County Sheriff's Office Rural Law Enforcement
Renu Garg-Peterlinz	Pool Of Consumer Champions (POCC)
Myel Jenkins	Sierra Health Foundation
Nga Le	Community Health for Asian Americans
Betty Malks	CA Elder Justice Coalition
Pamlyn Millsap	Eureka Police Department
Ralph Nelson	MHSOAC
Victor Ojakian	Asian Americans for Community Involvement (AACI)
Tara Pir	Institute for Multicultural Counseling & Education Services (IMCES)
Suamhirs Rivera	Youth In Mind
Stephen Salva	CA Association of School Counselors
Peter Schroeder	Mental Health Association in CA
Tracy Tripp	Ione Band member of Miwok Indians
Karen Ventimiglia	County of San Diego
Ken White	Ken White & Associates
Scott Whyte	Stigma Elimination Task Force
Chong Yang	Stanislaus Behavioral Health and Recovery Services
Sally Zinman	CA Client Action Workgroup

SDR CONSORTIUM VISION STATEMENT

Californians embrace evolutionary movement for wellness through social inclusion and social justice.

SDR CONSORTIUM VALUES

Our overarching PRINCIPLE is:
To reduce mental health stigma and discrimination by promoting wellness, social justice and social inclusion by framing and articulating our work around the following VALUES:

1. People first: recognize and utilize the strengths of individuals, families, friends and community allies to reduce stigma and discrimination and foster recovery, resiliency and wellness for all.

2. Respect and promote responsiveness to California's diversity of culture, ethnicity, age, sexual orientation and all people from un- and underserved populations in various geographic locations (urban, suburban, rural).

3. Support transparency and open dialogue to promote wellness, social justice and social inclusion.

4. Recognize and support collaboration between and among public and private sectors within and outside of the public mental health system to assure systemic and sustainable change.

5. Emphasize the importance of resiliency, recovery and wellness by supporting the development and research of creative and innovative consumer and family driven approaches to reduce mental health stigma and discrimination.

6. Commitment to learning within a historical framework and working toward evolutionary progress.

SDR CONSORTIUM ROLE

Our ultimate ROLE is:
To share our collective experience to inform and partner with CalMHSA and its Program Partners to reduce mental health stigma and discrimination by improving outcomes that promote wellness, social justice and social inclusion by being or doing the following:

1. Be an ambassador, liaison, and advocate for consumers, families, and communities through sharing our collective experiences to reduce mental health stigma and discrimination by promoting wellness, social justice and social inclusion.

2. Be a think tank, consultant, and advisor for CalMHSA board and staff regarding essential elements of stigma and discrimination reduction in statewide programs and policies.

3. Promote wellness, social justice and social inclusion with the goal of reducing mental health stigma and discrimination through our own work product, partnership with CalMHSA statewide partners, and other possible statewide collaborations.

4. Identify and support the dissemination of consumer and family driven best practices aimed at reducing mental health stigma and discrimination through a clearinghouse and local contacts, particularly in partnership with the California Center for Dignity, Recovery & Stigma Elimination.

5. Encourage and help shape public policy that reduces mental health stigma and discrimination through promotion of wellness, social justice and social inclusion.

SDR CONSORTIUM OUTCOMES

CALMHSA AND CALMHSA PROGRAM

Outcome 1: Build strong relationships with CalMHSA Program Partners and CalMHSA to reduce mental health stigma and discrimination by promoting wellness, social justice and social inclusion as evidenced by:

- Meeting with all SDR Program Partners (Disability Rights California; Entertainment Industries Council, Inc.; Mental Health Association of San Francisco; NAMI California; Runyon, Saltzman & Einhorn; United Advocates for Children & Families; Community Clinics Initiative; Mental Health America of California) to learn about their work, share the Consortium's Strategic Work Plan and description of assistance offered by the Consortium;

- Meeting with key liaisons/Program Partners for the Student Mental Health & Suicide Prevention Initiatives in order to learn about their work, share the Consortium's Strategic Work Plan, description of assistance offered by the Consortium, encourage and strategize about programmatic recommendations for SDR via promotion of wellness, social justice and social inclusion;

- Strengthening the Consortium's understanding of Program Partners' work through review of quarterly Initiative Reports and presentations by Program Partners;

- Sharing SDR Consortium Recommendations Forms with Program Partners after presentations to the Consortium, and a summary of those recommendations to CalMHSA;

- Strategizing with Program Partners from all Initiatives, key CalMHSA staff, and CalMHSA Board members about opportunities to strengthen/leverage SDR efforts through integration/coordination of work both within and across Initiatives;

- Review future work products of CalMHSA Statewide PEI Program Partners to assure promotion of SDR.

STATEWIDE NETWORK FOR MENTAL HEALTH SDR SUSTAINABILITY

Outcome 2: Promote sustainability of wellness, social justice and social inclusion efforts to reduce mental health stigma and discrimination by cultivating opportunities for development of an integrated network of local and state level partners and coalitions, both within and outside of the mental health system as evidenced by:

- Sharing Consortium vision and aligning with local and state level partners and coalitions;

- Maintaining ongoing dialogues with local and state level partners and coalitions both within and outside of the mental health system;

- Developing a self-sustaining network of local and state level subject matter experts, as well as CalMHSA Program Partners, as an organizing body in order to coordinate, leverage and advocate for SDR work throughout California;

- Collaborating with Disability Rights California to developing one informational "white paper" for distribution to private sector organizations (including but not limited to business, employers, private foundations, insurance industry, law enforcement, faith/spiritual groups, K-12 and higher education, health and mental health, social services, consumer and client organizations, family organizations, military partners, County Behavioral Health) addressing the commonality of mental health challenges, with recommendations or action steps that can be taken to promote SDR, wellness, social justice and social inclusion in each sector. Developing a statewide plan for media release including a minimum of 3 public relations efforts, dissemination of a minimum of 1,000 print copies of the "white paper", and make an electronic printable version available for wide distribution throughout the state to private sector organizations.

- As a component of Mental Health Association of San Francisco's March 21-22, 2013 resource dissemination conference, host an SDR policy/advocacy working meeting track, designed in collaboration with local and state level partners and coalitions, both within and outside of the mental health system, in order to develop and implement a coordinated statewide SDR Plan.

ROLES OF CONSUMERS & FAMILY MEMBERS

Outcome 3: Support meaningful roles for consumers and family members in mental health SDR advocacy, education and collaboration aimed at promoting wellness, social justice and social inclusion by being a champion of causes as evidenced by:

- Strengthening the Consortium's understanding of Program Partners' work with consumers and family members by reviewing quarterly summaries of Partner Reports on the role of these stakeholders in PEI projects;

- Evaluating the impact/benefit of working with consumers and family members in CalMHSA contracts;

- Collaborating with Mental Health America California, and building on previous efforts including the Working Well Together Report, research, identify and synthesize a report on benefits of working with people with lived experience to promote transformation of stigma and discrimination to wellness, social justice and social inclusion. Developing a statewide plan for media release including a minimum of 3 public relations efforts, and dissemination of a minimum of 1,000 print reports, as well as statewide availability of an electronic printable version of the report;

- Educating legislators, making recommendations and advocating for increased roles and positions for consumers and family members in the formulation of mental health SDR policy, program design, implementation, and service provision.

POLICY & ADVOCACY
Outcome 4: Increase advocacy to promote mental health stigma and discrimination reduction policies as evidenced by:

- Collaborating with Disability Rights California on development of report on strategies for changing organizational practices in order to reduce mental health stigma and discrimination, as well as a statewide dissemination plan for the report, distributing a minimum of 1,000 copies of the report and making electronic printable version of the report available statewide;

- Establishing collaborative relationships with 10 group representing diverse sectors and disciplines from across the state, both within and outside of the mental health system, including SDR Program Partners, to develop a strategy for implementation of 2 statewide mental health stigma and discrimination reduction policies/strategies;

- Working with groups such as Mental Health Association of San Francisco, NAMI, and UACF, as well as groups that can appropriately represent diverse ethnic and cultural communities, to educate 20 elected officials and their staff about the impact of mental health stigma and discrimination, its unintended consequences on their constituents, and best practices for its reduction.

ENGAGING DIVERSE COMMUNITIES
Outcome 5: Educate and engage diverse community sectors in the SDR conversation about wellness, social justice and inclusion as evidenced by:

- Seeking ways to partner with California Reducing Disparities Project (CRDP), and identifying resources to support this collaboration in order to build on CRDP's statewide PEI disparity reports for African American, Asian & Pacific Islander, Latino, LGBTQIAS, and Native American communities. In collaboration with CRDP, identifying how the reports can serve as guides in developing "toolkits" to engage these diverse communities in culturally relevant ways in conversations about SDR, wellness, social justice and social inclusion. Developing a statewide dissemination plan for "toolkits," distribute a minimum of 1,000 toolkits

statewide, and making electronic printable version of the “toolkits” available to diverse community sectors statewide.

Enhancing Efforts to Reduce Disparities through the Statewide Mental Health Services Act Prevention and Early Intervention Programs

A project of the California Institute for Mental Health commissioned by the California Mental Health Services Authority

Final Report

Spring 2013

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Acknowledgements

The California Institute for Mental Health (CiMH) was established in 1993 to promote excellence in mental health services through training, technical assistance, research and policy development. Local mental health directors founded CiMH to work collaboratively with all mental health system stakeholders. The commitment to collaboration has led the board to expand board membership to include consumers, family members, and other interested persons representing the public interest. CiMH's purpose is to promote wellness and positive mental health and substance use disorder outcomes through improvements in California's health systems.

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Executive Summary

In the summer of 2012, CalMHSA contracted with the California Institute for Mental Health (CiMH) and consultant Katherine Elliott to conduct a cultural competence and technical assistance assessment of its 25 statewide Prevention and Early Intervention (PEI) contractors referred to as Program Partners. The Program Partners were contracted to implement projects across three PEI program areas: Stigma and Discrimination (SDR), Suicide Prevention (SP), and the Student Mental Health Initiative (SMHI). CalMHSA's request for the assessment recognized the extensive and growing diversity of California's population, as well as, the importance of understanding the role of cultural responsiveness in relation to its impact on the stigma of mental illness and resulting discrimination, suicide prevention strategies across the lifespan and strategies for student populations. CiMH agreed to conduct the assessments, provide direct feedback to the Program Partners, and offer to CalMHSA training and technical assistance recommendations that would have an immediate impact on Program Partners' efforts to strengthen products and services for racial, ethnic, and cultural communities across the statewide PEI initiatives.

This study was designed to assess the organizational cultural competence of the Program Partners, as well as to ascertain their capacity to develop culturally responsive products and services that would yield high impact in un-served, underserved, and inappropriately served ethnic and racial populations. This included an examination of Program Partners' current programs, strategies, and deliverables, as well as the development of recommendations for improving services and strategies for racial, ethnic, and cultural populations.

Twenty-five of CalMHSA's PEI Program Partners were interviewed as a part of this project. The assessment protocol included a review and analysis of source materials (i.e., contract scope of work, detailed work plans, quarterly reports, and contract deliverables), a 90-minute telephone interview with Program Partners, and an online survey.

From the assessment several themes emerged, including challenges regarding: the development of relationships with communities, implementation of language access services, data collection, and culturally appropriate adaptations of products and services. The following findings and recommendations are organized into two categories: strategies to enhance cultural responsiveness of products and services and strategies to improve organizational cultural competence.

Recommendations to enhance cultural responsiveness of products and services:

1. Utilize culturally appropriate community-defined practices to adapt products and services for targeted racial and ethnic populations
2. Improve strategies for collecting and analyzing demographic data by race, ethnicity, sexual orientation and gender identity
3. Enhance linguistic competence and language access by providing appropriate translation and interpretation services

4. Develop culturally appropriate strategies for assessing the impact of project implementation in targeted un-served, underserved and inappropriately served communities

Recommendations to improve organizational cultural competence:

1. Strengthen and/or build formal relationships with community members and community-based organizations for the purpose of institutionalizing relationships with un-served, underserved, and inappropriately served communities
2. Create a mechanism for regular, on-going self-assessment of organizational cultural competence and capacity to be responsive to racial, ethnic, linguistic and cultural populations
3. Continually assess individual staff development needs and skill-sets necessary to ensure cultural responsiveness

All of the Program Partners demonstrated and unequivocally affirmed a commitment to cultural competence and responsiveness. Most, if not all, of the Program Partners reported challenges related to capacity, resource allocations, and prioritization in their efforts to demonstrate cultural responsiveness. Continued support of the PEI Initiatives, by offering opportunities for training and technical assistance for the purpose of implementing the recommended strategies, would assist Program Partners to overcome these challenges. A more detailed description of the recommendations highlighted above can be found within the body of the report. The recommendations in this report are intended to help Program Partners to strengthen internal capacity and ensure cultural responsiveness of PEI products and services; thereby improving the outcomes for racial, ethnic and cultural communities across the statewide projects. In doing so, resources dedicated to this work provide an investment for lasting changes to enhance efforts to reduce disparities.

Background and Project Overview

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop 63). Proposition 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

The MHSA Statewide Prevention and Early Intervention (PEI) Initiatives include Suicide Prevention (SP), Stigma and Discrimination Reduction (SDR), and the Student Mental Health (SMHI) Initiative. Central to CalMHSA's vision is the promotion of systems and services arising from community mental health initiatives, as well as supporting the six principles of the MHSA: 1) Community collaboration; 2) Cultural competence; 3) Client-driven mental health system for individuals across the lifespan who are receiving or have received mental health services; 4) Family-driven mental health system for families of children and youth diagnosed with serious emotional disturbance; 5) Wellness, recovery and resilience focused;

and, 6) Integrated service experiences for clients and their families (CalMHSA, Statewide Implementation Work Plan, 2010). CalMHSA conducted a statewide stakeholder process to aid in the development of its Statewide PEI Implementation Work Plan, which provides a framework for implementing MHSA PEI funds.

In 2010, CalMHSA, in collaboration with the California Institute for Mental Health (CiMH), issued three Requests for Proposals (RFP) to engage partners in the implementation of the three statewide PEI initiatives. The original RFPs outlined the expected outcomes for each of the initiatives and identified guiding principles for the completion of all deliverables, as detailed in the Implementation Work Plan. The Work Plan's guiding principles and policy directions are as follows:

- Each statewide program should be complementary to the other programs (e.g., the Suicide Prevention Program should address how its design complements stigma and discrimination reduction and vice versa) and should complement other state, regional and local resources
- All programs should be inclusive of stakeholder involvement
- All programs should be culturally and linguistically competent, respectful and inclusive of California's diverse population across all age groups including seniors
- All programs should have a lifespan appropriate focus for children, transition age youth and transition age foster care youth, adults and older adults
- All programs should address California's geographical diversity, ranging from small communities spread over large rural areas to metropolitan areas with suburban expanse and urban density
- All programs should optimally leverage federal, state and local resources
- All programs should be achievable with four years' funding
- All programs should support data driven policy and evidence based, promising and community defined practices
- All programs should improve the cultural competence and appropriateness of suicide prevention activities
- Available resources will limit the scale of implementation

These principles and the RFP language set the foundation for and mandated a focus on cultural competence and cultural responsiveness in the implementation of the statewide PEI Initiatives.

Cultural Competence

California is the third largest state in the United States, encompassing 163,696 square miles. There are 58 counties and 2 city programs in California, with Los Angeles as the county with the largest population, and San Bernardino as the largest county by area. The racial and ethnic demographics of the state are rapidly changing. According to the United States Census Bureau, 39.7 percent of Californians identify as "White" resulting in 60.3 percent of the population identifying as a member of a different ethnic or racial group or belonging to more than one race or ethnicity. Moreover, the State of California's Department of Finance Population Projections (2013) predicts, "…early in 2014, the Hispanic population will become the plurality in California for the first time since California became a state. By 2060, both

the Black and the White populations will have increased in size, but decreased in proportion to the total population. Hispanics will comprise nearly half (48 percent) of all Californians. Asians will also grow significantly in population, but only marginally relative to the total population to just over 13 percent from their current level of just under 13 percent. " (State of California, Department of Finance, 2013)

Given this demographic profile, the behavioral health system must be prepared to respond to the complex needs of California's racial and ethnic communities by providing high quality culturally appropriate and responsive services. Cultural competence was defined in 1989 by Terry Cross et al as, "A set of congruent behaviors, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations." (T. L. Cross, Bazron, B., Dennis, K.W., & Isaacs, M., 1989) Cultural competence has been operationalized through policies at the national, state, and local levels. For example, the California Code of Regulations has identified specific goals by which to achieve cultural competence and states that cultural competence should be achieved by incorporating the goals into all aspects of policy-making, program design, administration and service delivery. (CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.100, Cultural Competence)

However, the field of cultural competence has evolved since Cross coined the term in 1989. Many experts in the field view cultural competence as a state of awareness of one's own ethnic, racial, and cultural identity in relation to those of other backgrounds or identities; and how those values and behaviors interface in community, organizations, and relationships. Increasingly, scholars of cultural competence lean toward concepts of cultural responsiveness (or cultural appropriateness), to describe appropriate behaviors or strategies to engage someone of a different racial, ethnic, or cultural background. The ideal condition of cultural *competence* has been considered by some to be too vague and not truly reflective of the type of outcomes communities need. While an organization should continue to strive for cultural competence by continually assessing its own capacity, resources, procedures, and practices, some organizations and providers may benefit from shifting their perspective to one of cultural responsiveness. Cultural responsiveness "honors the voices, strengths, leadership, languages, and life experiences of ethnically and culturally diverse consumers and their families across the lifespan." (Alameda County Behavioral Health Care Services, African American Utilization Report, 2011) Cultural responsiveness is evident when communities are integrated into the planning, development, implementation, and evaluation of products and services intended for use in racial, ethnic, and cultural communities.

Evaluation and Assessment of Statewide PEI Initiatives

In the fall of 2011, CalMHSA entered into contract with the RAND Corporation to strategically plan and conduct a comprehensive statewide evaluation of CalMHSA's Suicide Prevention (SP), Stigma and Discrimination Reduction (SDR), and Student Mental Health (SMH) Initiatives. Currently, the RAND evaluation team is collaborating with the PEI Program Partners to carry out the following evaluation aims:

- Evaluate PEI Program Partners' progress toward meeting statewide objectives;

- Assess the activities implemented and resources created by PEI Program Partners;
- Evaluate program outcomes, including:
    - Targeted program capacities and their reach (e.g., provision of services, social marketing, workforce training);
    - Short-term outcomes (e.g., attitudes and knowledge about mental illness, behavior toward people with mental illness); and
    - Longer term outcomes (e.g., reduced suicide, reduced discrimination, improved student performance).

As a supplement to RAND's evaluation of the PEI Initiatives and in recognition of the challenges of California's extensive diversity, and to ensure the PEI Program Partners were poised to achieve positive outcomes for un-served, underserved, and inappropriately served racial and ethnic communities in California, CalMHSA contracted with the California Institute for Mental Health (CiMH) and consultant Katherine Elliot to conduct a cultural competence and technical assistance assessment of the 25 statewide Prevention and Early Intervention (PEI) Program Partners (See Appendix A, CalMHSA's PEI Program Partners) in the three PEI program areas. CiMH agreed to conduct the assessments, provide direct feedback to the Program Partners, and provide to CalMHSA training and technical assistance recommendations that would have an immediate impact on Program Partners' efforts to strengthen products and services for racial, ethnic, and cultural communities across the statewide PEI initiatives.

This study was designed to assess the organizational cultural competence of the Program Partners, as well as to ascertain their capacity to develop culturally responsive products and services that would yield high impact in un-served, underserved, and inappropriately served ethnic and racial populations. This included an examination of Program Partners' current programs, strategies, and deliverables. This report is a summary of the findings and recommendations that emerged from the assessment.

Methods

The individual statewide PEI initiatives are diverse in both magnitude and scope, with projects ranging from program-based primary care and behavioral health integration activities to anti-stigma social marketing efforts; from improving student mental health efforts to large-scale suicide prevention activities. Furthermore, the Program Partners implement their programs in a vast array of settings and mediums, including: statewide marketing campaigns, K-12 schools, universities/colleges, government, community based organizations, and clinics. They represent consumer-led and family member organizations; policy, advocacy, and technical assistance organizations; as well as a variety of sectors, including: mental health, alcohol and other drug services, education, and law enforcement.

The assessment protocol included a review and analysis of source materials (i.e., contract scope of work, detailed work plans, quarterly reports, and contract deliverables), a 90-minute telephone interview, and an online survey. Prior to the commencement of the interview phase, the assessment team conducted a literature review of several existing organizational assessment tools to design the assessment protocol.

As a result of the literature review, eight domains of cultural competence were adopted as the foundation for the cultural competence assessment. These eight cultural competence domains were utilized in the development of interview questions (See Appendix B, Interview Questions) as overarching themes for the assessment: 1) Organizational Values; 2) Policies and Procedures; 3) Planning, Monitoring, and Evaluation; 4) Communication; 5) Human Resources Development; 6) Community and Consumer Participation; 7) Facilitation of Broad Service Array; and, 8) Organizational Resources. (T. L. Cross; Harper, 2006; Siegel et al., 2011) Additional follow-up or prompting questions were also developed to elicit specific responses from Program Partners.

Each organization was invited to participate in a 90-minute web-based interview utilizing GoToMeeting software. The interviews began with introductions, a brief overview of the project, and an overview of cultural competence. The Program Partners were then led through a discussion about their organization's cultural competence across the eight domains identified in the protocol. Program Partners were also given the opportunity to provide updates about their program and indicate their self-identified technical assistance needs.

In addition to completing the 90-minute interview, Program Partners were asked to complete an online survey (See Appendix C, Program Partner Organizational Self-Assessment Tool). The purpose of the online survey was to supplement the interview discussions and for the Program Partners to provide detailed demographic information about the populations served, language capacity within the organization, as well as to allow Program Partners to conduct a self-assessment of their organization's cultural competence.

Finally, in order to better ascertain the Program Partners' current capacity to be culturally responsive and develop products and services that would have high impact in ethnic and racial communities, the assessment team reviewed selected deliverables from each Program Partner, including: training curricula, policy and environmental scans, marketing strategies (e.g., websites, billboards, etc.), needs assessments, etc.

Findings and Recommendations

Due to the diversity of the PEI initiatives, Program Partners, settings, strategies, and systems, it was not possible to identify a single technical assistance strategy that would provide an overall benefit to the Program Partners. No "one size fits all" training and technical assistance approach would be effective in improving the cultural competence of these organizations within the time allocated for implementation. Understanding the nature of the statewide PEI initiatives (i.e., limited funding and relatively short timeline for the project implementation), the goal of the assessment project was not to have an immediate impact on the Program Partners' organizational cultural competence. Rather, the assessment provides a snap shot perspective of the Program Partners' knowledge, practices, and capacity to be culturally responsive to California's un-served, underserved, and inappropriately served racial, linguistic, ethnic, and cultural populations. The more effective the organization is in achieving cultural competency

and demonstrating cultural responsiveness; the more likely they are to produce and implement effective culturally appropriate products and services.

Overall the Program Partners demonstrated a clear commitment to cultural competence and cultural responsiveness. They were positive and proactive about collaborating with the interview team in the assessment process. Most of the Program Partners were candid about their challenges and eager to engage with the assessment team about potential solutions and strategies to enhance their current efforts and improve their overall ability to appropriately serve racial, ethnic and cultural communities.

Specific strengths varied widely among Program Partners. For instance, some Program Partners reported strong community partnerships and a solid foundation within the community; while others indicated challenges in this area. Most, if not all, of the Program Partners spoke candidly of a desire to tailor and adapt products, services, and marketing strategies for specific audiences. However, these same Program Partners expressed concerns around resources, staffing, and training necessary to be successful with these endeavors.

From the assessment several themes emerged, including challenges regarding the development of relationships with communities, implementation of language access services, data collection, and culturally appropriate adaptations of products and services. The following findings and recommendations are organized into two categories: strategies to enhance cultural responsiveness of products and services; and strategies to improve organizational cultural competence.

Strategies to enhance cultural responsiveness of products and services:

1. *Utilize culturally appropriate community-defined practices to adapt products and services for targeted racial and ethnic populations*

It is particularly important to understand the role of cultural responsiveness in relation to its impact on the stigma of mental illness and resulting discrimination, trauma resulting from racism and discrimination, and suicide prevention strategies across the lifespan and for student populations in particular through the SMHI. The experience of having a mental illness, or having a family member with mental illness, is uniquely shaped by a person's racial, ethnic, and cultural framework and norms. The willingness and ability to access mental health services is influenced by cultural values, beliefs, history, and experiences. Many diverse ethnic and linguistic populations often do not have language that describes mental health concepts or a nosology that defines mental illness (California Department of Mental Health, Office of Multicultural Services, 2010).

Differences in attitudes and behaviors exist across age groups, acculturation levels, rural/urban communities, education, economic status, documentation status, sexual orientation, and gender identity. Using these dimensions to plan services is a complex process. It requires intimate knowledge of the target population and a plan for addressing the culturally based considerations needed to implement culturally appropriate programs and services. Understanding the uniqueness of these intersections of identity is critical to effective implementation of the statewide PEI initiatives to reduce stigma and discrimination, to improve student mental health, and to prevent suicides. The messaging,

interventions, education, health promotion, outreach and engagement strategies must all be tailored to meet the unique needs of diverse racial, ethnic, and cultural communities.

Several of the PEI initiatives include training components utilizing existing evidence-based or best practice curricula. Some Program Partners conducting these trainings for diverse audiences report lacking the scope and breadth of skills and resources to appropriately adapt these curricula/programs to make them culturally appropriate for a range of diverse target populations.

CalMHSA has provided exposure to The California Reducing Disparities Project (CRDP) Reducing Disparities Population Reports through technical assistance calls and TA bulletins. CalMHSA has also actively encouraged Program Partners to become very familiar with the rich content these reports provide. While the content in these reports should serve as guiding resources for all statewide PEI initiatives, the information contained in the reports is extensive and it can be complex to understand how to best use the information on a day-to-day basis. The strategies and recommendations included in the reports were defined by and developed for Native American, African American, Asian/Pacific Islander, Latino, and Lesbian, Gay, Bisexual and Transgender communities. The CRDP Population Reports offer rich insights, resources, strategies and promising practices to address disparities, as well as opportunities to enhance the reach and cultural responsiveness of the Program Partners' initiatives. In addition, with a further examination of existing data collected for the Reducing Disparities Population Reports, more insight regarding cultural considerations for SDR, SP and SMH could be extracted and applied to existing and future PEI projects, both statewide and locally.

2. *Improve culturally appropriate strategies for collecting and analyzing demographic data by race, ethnicity, sexual orientation and gender identity*

Participating in RAND's evaluation will likely assist Program Partners with improving or identifying strategies to collect demographic data by race and ethnicity; however, some of the Program Partners would benefit from more guidance regarding culturally appropriate strategies for collecting data. Some SP partners do not collect demographic data for hotline callers for several reasons ranging from concerns over interfering with engagement to lack of capacity; and they may have limited information about volunteers and training participants. Most of the Program Partners expressed specific challenges around collecting sexual orientation and gender identity data for participants and volunteers. For those who do collect this data additional training on analyzing the data and to utilizing it to inform programs and initiatives is needed.

3. *Enhance linguistic competence and language access by providing appropriate translation and interpretation services*

Investing resources to ensure linguistic competence, specifically the accessibility of services and products, is a critical component of organizational cultural competence and cultural responsiveness. In California, Latinos represent a large proportion of the population; as such Spanish is considered a threshold language statewide. While the initial contracts did not require it, some of the Program Partners do provide some materials in Spanish. For example, two of the social media/marketing campaigns have invested extensive resources and created specific marketing strategies in Spanish.

However, the overall linguistic capacity of the Program Partners is limited (e.g., absence of bilingual staff, use of un-trained staff to translate materials). Program Partners often lack adequate resources to provide translation of written materials[1] and report limited ability to provide interpretation, when appropriate (i.e. suicide prevention hotlines, trainings, etc.). Further, Program Partners implementing public services and/or trainings too often have to rely upon language lines and/or under-trained volunteers to ensure linguistic accessibility. The provision of bi-lingual services and translated products is essential to ensure accessibility and responsiveness to the needs of a bi-lingual, monolingual, and/or Limited English population.

4. *Develop culturally appropriate strategies for assessing the impact of project implementation in targeted un-served, underserved and inappropriately served communities*

Program Partners will be working in conjunction with the RAND Corporation to identify and develop formal strategies, procedures, and tools to continually assess their PEI projects relative to the impact and outcomes for racially, ethnically, linguistically, and culturally diverse populations. Each organization should implement a strategy to collect demographic data for its workforce, volunteer base, and training participants, as well as a mechanism to capture service utilization data (i.e., suicide hotline callers). Program Partners should collaborate with community partners to analyze and interpret results of data collection efforts in order to inform on-going and future strategies and PEI initiatives.

Strategies to improve organizational cultural competence:

1. *Strengthen and/or build formal relationships with community members and community-based organizations for the purpose of institutionalizing relationships with un-served, underserved, and inappropriately served communities*

Program Partners reported challenges related to relationship building with racial, ethnic, and cultural communities and were eager for support to address these challenges. Many Program Partners discussed challenges engaging specific communities (i.e., Native American, Asian/Pacific Islander, and LGBT populations, etc.), despite reported strong relationships in Latino and African American communities. The most commonly cited challenge to implementing programs in collaboration with these communities was the lack of bilingual/bicultural staff to conduct appropriate outreach and/or the lack of connections with community based cultural brokers. In cases in which Program Partners have formed partnerships with CBO's and community leaders, these relationships are often not sufficiently developed to ensure adequate participation to achieve the desired outcomes (i.e., planning, development, implementation, and evaluation of products and services) as many of these relationships are informal and lack sustainability. The connection that exists between the organizations is often characterized as an individual relationship between staff as opposed to a formal partnership between the organizations; this hampers the organizations' ability to achieve common goals. For example, when these particular staff members (from either organization) leave their positions, the relationships are often lost and the Program Partners are forced to start over and rebuild their networks.

[1] Subsequent to the assessment interviews, CalMHSA issued contract amendments to address these issues by providing additional resources to Program Partners.

Some of the Program Partners have begun developing relationships with statewide entities advocating for racial and ethnic communities by inviting the cultural brokers and representatives of racial and ethnic communities to serve on boards of directors and advisory committees, and participate in strategic planning and organizational development efforts. The advisory committee strategy allows the Program Partners to build capacity within their organization; as well as the opportunity to navigate and support sustainable relationships with community representatives. By starting with a small targeted advisory groups and building capacity over time, Program Partners will be better positioned to gain access to and develop long-term relationships with communities.

2. *Create a mechanism for regular, on-going self-assessment of organizational cultural competence and capacity to be responsive to racial, ethnic, linguistic and cultural populations*

One of the beneficial outcomes of this cultural competence and technical assistance assessment is the self-reflection and organizational assessment that each of the Program Partners underwent in response to the assessment interview and survey. All of the organizations interviewed affirmed a clear commitment to cultural competence. At the same time all of the organizations have room for growth in this area. Enhancing one's cultural competence and cultural responsiveness is an ongoing process that any organization, not just the ones participating in this program, should commit to. Regardless of the starting place for each of the Program Partners, all of the programs had to assess their programs and strategies through a cultural competence lens in order to respond to the interview questions. Continuing with this process of self-assessment will be helpful in furthering the development of Program Partners' cultural competence and cultural responsiveness.

3. *Continually assess individual staff development needs and skill-sets necessary to ensure cultural responsiveness*

It is often believed that cultural competence training is a one-time event; however, it does not have an endpoint at which an individual or an organization achieves "competence". It requires a, "commitment and active engagement in a lifelong process that individuals enter into on an on-going basis with patients, communities, colleagues, and themselves." (Tervalon & Murray-Garcia, 1998) This idea of ongoing commitment to cultural competence is applicable to prevention and early intervention as well as clinical practice. The skillsets and training needs of providers and staff should be continually assessed and developed. Even organizations with diverse bilingual workforces need regular training and staff development; just having staff members "from the community" or "representative of the community" does not necessarily equate to competence and expertise.

Many of the Program Partner organizations are small agencies with limited staff and resources and unable to commit necessary resources for on-going skill building for cultural competence. The majority of the larger organizations also failed to allocate adequate resources to training and staff development in the area of cultural competence and cultural responsiveness. Additional training and technical assistance to support these organizations' current efforts could provide Program Partners with strategies necessary for infusing on-going cultural competence training into their regular practice and to

ensure that Program Partners are able to achieve the best possible outcomes for the diverse population of California.

Discussion and Next Steps

Consistent with the timeline for implementation of the statewide PEI initiatives, this assessment was conducted within a relatively short timeframe and limited budget. As a result, the scope was confined to the perspectives of only a few providers within each Program Partner organization. Ideally, cultural competency assessments would incorporate site visits, and include in-depth interviews of clients and family members in addition to agency staff, as well as observations of the physical and virtual settings (if appropriate for the organization). This would result in a more comprehensive assessment of how well the Program Partners are reaching and serving a diverse clientele. Assessment and evaluation of the resulting services and products should incorporate community members representing racially, ethnically, linguistically, and culturally diverse populations.

All of the Program Partners demonstrated and unequivocally affirmed a commitment to cultural competence and responsiveness. Most, if not all, of the Program Partners reported challenges related to capacity, resource allocations, and prioritization in their efforts to demonstrate cultural responsiveness. Continued support for the statewide PEI Initiatives, by offering opportunities for training and technical assistance for the purpose of implementing the recommended strategies, would help Program Partners overcome these challenges. If implemented, the recommendations in this report would help Program Partners to build internal capacity to ensure cultural responsiveness of PEI products and services; thereby strengthening the outcomes for racial, ethnic and cultural communities across the statewide projects. Specifically, CalMHSA should provide additional resources and support in the form of the following technical assistance activities:

1. Establish a supported opportunity for knowledge exchange utilizing web based mediums. For instance, web-based partner cohorts would give Program Partners an opportunity to workshop their deliverables, share challenges, and spread ideas for learning, quality improvement, and implementation of best practices. Through this strategy, CalMHSA can continue to foster and strengthen interagency collaboration between the Program Partners beyond the bi-annual Statewide Coordination Workgroup convening of the Program Partners.

2. Provide one-on-one technical assistance, at the request of the CalMHSA contract manager and/or the Program Partners, to improve cultural responsiveness and enhance outreach and engagement strategies to reach un-served, underserved, and inappropriately served populations.

3. Engage cultural brokers and community experts to enhance understanding of cultural differences and distinctions within suicide prevention, stigma and discrimination reduction, and student mental health.

4. Develop strategies to adapt and incorporate cultural competence and cultural responsiveness into daily program delivery and overall organizational structure.

CalMHSA, through the statewide PEI initiatives has a unique opportunity to develop culturally appropriate models for rendering high quality services and products to address the suicide prevention, student mental health and stigma & discrimination reduction needs of un-served, underserved, and in-appropriately served populations across California. Future assessments of statewide Prevention and Early Intervention programs should expand the focus of the assessment to address some of the limitations of this assessment project.

Appendices

A. CalMHSA's PEI Program Partners

Suicide Prevention Partners

AdEASE

Didi Hirsch Mental Health Services

Transitions Mental Health

Family Services Agency, Central Coast

Family Services Agency, Marin

San Francisco Suicide Prevention

Institute on Aging

Kingsview Behavioral Health Services

LivingWorks

Stigma and Discrimination Reduction Partners

Runyon Saltzman & Einhorn

United Advocates for Children and Families

Mental Health Association of San Francisco

Mental Health Association in California

Entertainment Industries Council, Inc.

Community Clinics Initiative – Integrated Behavioral Health Project

National Alliance for Mental Illness, California

Disability Rights of California

Student Mental Health Initiative Partners

California Department of Education

California County Superintendents Education Services Association

California State University Office of the Chancellor

University of California, Board of Regents

California Community Colleges

B. Interview Questions with Prompts

CalMHSA, in collaboration with the California Institute of Mental Health (CiMH), is conducting cultural competence needs assessment and technical assistance project to assist program partners in meeting the needs of underserved communities. The following questions will be addressed in interviews with program partners. These questions are provided to you in advance to allow time for reflection and information gathering. Please be prepared to provide responses and examples for the questions listed below. Thank you for your willingness to participate in this project.

1. What challenges do you face in promoting cultural competence in the Student Mental Health Initiative project?

2. How does your organization explicitly demonstrate its commitment to cultural competence in its policies and procedures?
   - Is the commitment explicit?
   - How is commitment to cultural competence demonstrated in institutional policies and practices?

3. How are you measuring your effectiveness with underserved communities?
   - Is race and ethnicity data collected?
   - What are your race/ethnicity categories?
   - What other population demographics are measured (LGBTQ, etc.)?
   - How does data collected reflect county/regional demographics
   - How are you using data to inform design, planning and implementation of services?
   - Do you have staff trained to analyze the data?
   - What have you done to address disparities evident in your data?

4. How does your organization deal with issues of linguistic diversity?
   - Do you provide translated materials, interpreter services?
   - What languages do you use?
   - Do these reflect the linguistic diversity of the community?
   - What is the process for translating materials?
   - How do you make these materials available? Examples?

5. How diverse is your personnel at all levels? What strategies do you have for enhancing diversity?
   - Does the diversity of your staff reflect the diversity of target communities?
   - What percentage of your top leadership reflects the diversity of the populations served?
   - What do you see as the benefits and value of staff diversity?
   - Have you developed an organizational culture that generally supports staff diversity?

- Are there organizational supports for staff members from minority groups? Do staff members for non-majority populations feel they carry a disproportionate amount of weight of advocacy for cultural competence within the organization?
- What kind of support and training does the organization provide regarding the cultures of the populations served?
- Training: Is there regular training provided regarding cultural issues? How often? What topics are covered? Who attends?

6. What is the nature of your organization's relationship to the community?

    - What is the involvement of communities and consumers in the design and implementation and evaluation of your project? How does the agency involve the broader community in its strategic planning, program development, and evaluation processes?
    - What formal relationships (contracts/MOUs) with community based organizations?
    - What is the role of consumers and family members in project?
    - What community events does your organization participate in?
    - What CBOs do you partner with?
    - Do you have relationships with local ethnic media providers?

7. How do the services provided reflect the specific needs of the diverse communities served?

    - How are programs tailored to meet the cultural needs of communities?
    - How are these needs assessed?
    - How do you know what they need and/or if you are providing what the communities need?
    - How do you incorporate cultural concerns and treatment needs of specific groups? (i.e. use of traditional healing practices)? Use of culturally appropriate diagnostic assessment, treatment planning tools?
    - Accessibility: flexible hours? Transportation? Child care? Welcoming environment? Convenient location?

8. What infrastructure exists to support cultural competence within the organization?

    - Is there a person in charge of cultural competence within the organization? What authority does this person have within the decision-making structure of the organization?
    - Is there an advisory committee charged with enhancing cultural competence?
    - Is there collaboration with cultural leaders, cultural brokers, cultural organizations, and faith based organizations?
    - Is there financial support (i.e., budgetary allotment) for cultural competence activities? Is this financial support within the jurisdiction of the cultural competence manager?
    - Technological infrastructure (i.e., on-line resources) that is accessible and reflects culturally competent values?

C. Program Partner Organizational Self-Assessment Survey2

This survey is intended to assist the California Mental Health Services Authority (CalMHSA) and the California Institute of Mental Health (CiMH) in identifying strategies to enhance Prevention and Early Intervention efforts. Your response to these questions will inform the cultural competence needs assessment and technical assistance project designed to assist program partners in meeting the needs of underserved communities. Thank you for taking the time to complete this survey.

1. What is today's date?

2. Contact Information?
   - Name
   - Company
   - Email Address
   - Phone Number

3. What is your title?

4. What is your role at the agency?

5. In what setting do you provide service? Check all that apply.
   - In School
   - School-Based (services provided to those recruited through schools but delivery of services mostly out of school)
   - AOD Treatment Program
   - Government Facility (jail, prison, public hospital, military base)
   - Clinic Setting (e.g. Primary Care, Mental Health, etc.)
   - Private Homes (in-home services, home visits, in-home interventions)
   - Internet (services are delivered through website/webinars/chat rooms/Facebook)
   - Organization Sponsored Events/Programs (events or programs that take place at your facility, or at facilities that your provide)
   - Community Agency (Please describe below)
   - Other (please specify)

6. How many people does your organization serve annually?

7. What racial or ethnic groups have a significant presence in your service area? Check all that apply.
   - African American/Black
   - American Indian/Native American

[2] Online survey sent via Survey Monkey.

- Biracial or multiracial
- Caucasian/White
- East Asian (i.e. Chinese, Japanese, Korean)
- Latino/Hispanic/Chicano
- Middle Eastern
- Pacific Islander (i.e. Hawaiian, Samoan, Guamanian)
- South Asian (i.e. Indian, Pakistani, Bangladeshi)
- Southeast Asian (i.e. Filipino, Vietnamese, Hmong)
- Others (please specify)

8. Which of the following cultural groups have a significant presence in your service area? Check all that apply.
    - Homeless
    - LGBTQ (lesbian, gay, bisexual, transgender, questioning)
    - Older Adults
    - People with disabilities
    - Veterans
    - Youth
    - None
    - Other (please specify)

9. What languages other than English are commonly spoken in your service area? Please check all that apply.
    - Arabic
    - Armenian
    - Cambodian
    - Cantonese
    - Dari
    - Farsi
    - French
    - Hindi
    - Hmong
    - Japanese
    - Korean
    - Mandarin
    - Persian
    - Russian
    - Spanish
    - Tagalog
    - Vietnamese
    - Other (please specify)

10. How familiar are you with the Culturally and Linguistically Appropriate Services (CLAS) standards?
    - Not at all familiar
    - Not very familiar
    - Somewhat familiar
    - Very familiar

11. Does your organization have TARGETED services, programs, or outreach efforts for any of the following racial or ethnic groups? Please check all that apply.
    - African American/Black
    - American Indian/Native American
    - Biracial or multiracial
    - Caucasian/White
    - East Asian (i.e. Chinese, Japanese, Korean)
    - Latino/Hispanic/Chicano
    - Middle Eastern
    - Pacific Islander (i.e. Hawaiian, Samoan, Guamanian)
    - South Asian (i.e. Indian, Pakistani, Bangladeshi)
    - Southeast Asian (i.e. Filipino, Vietnamese, Hmong)
    - Others (please specify)

12. Does your organization have TARGETED services, programs, or outreach efforts for any of the following cultural groups? Please check all that apply.
    - Homeless
    - LGBTQ (lesbian, gay, bisexual, transgender, questioning)
    - Older Adults
    - People with disabilities
    - Veterans
    - Youth
    - None
    - Other (please specify)

13. For each of the following, please rate how well your organization performs (Not well at all; Not very well; Somewhat well; Very well; Don’t know):
    - How well does your organization know the racial and ethnic demographics of its service community?
    - How well aware is your organization of the presence of other culturally identified groups in its service community?
    - How well does your agency make the office environments welcoming to diverse communities?

- How well does your organization leverage strengths of its service population?
- How well does your organization incorporate strategies to address social determinants of health?

14. Please answer yes or no for the following.
    - Has your organization formally identified cultural competence as a service goal?
    - Does your organization have a written non-discrimination policy?
    - Does this policy also ban harassment and hate speech (i.e. slurs and insults based on race, ability, sexual orientation, or gender identity?

15. Please rate your organization's performance on the following measures.
    - How well does the cultural and linguistic profile of your organization's staff reflect the cultural and linguistic profile of your service community?
    - How well does your organization accommodate the spiritual, cultural, and religious diversity of its staff?

16. Is training in cultural competence part of employee training?
    - Yes, for all employees
    - Yes, for new employees
    - No

17. How well does this training equip staff members to more effectively serve diverse cultural groups?
    - Not well at all
    - Not very well
    - Somewhat well
    - Very well
    - Don't know

18. Does your organization have a formal policy to grow and support a diverse workforce to reflect the community it serves?

19. Please rate how well your organization performs on the following measures (Not well at all; Not very well; Somewhat well; Very well; Don't know):
    - How well your organization understands and responds to the cultural needs of its clients? (i.e. responding to the different needs of diverse cultural groups such as, older adults with mobility problems, youth who communicate via text message, homeless people without addresses, women with children, people in same sex relationships, transgender people, cross generational conflict)
    - How well does staff advocate for diverse populations?
    - How well does staff understand the diverse cultural beliefs about substance use, abuse, and treatment in its service community?

- How well does your organization understand the gender-specific needs of women (i.e. domestic violence intervention, sexual abuse counseling, parenting supports)?
- How well does you organization accommodate clients with particular spiritual/cultural/religious needs (i.e. scheduling around religious or spiritual observances, or trans-inclusive policies for gender-specific environments)?
- How well does your organization accommodate people with disabilities? (i.e. ADA-compliant accessibility in the physical environment, scent free, large print, services for the deaf and hard of hearing)

20. What further resources does your organization need to meet the cultural needs of its clients?

21. Does your organization provide services in languages or dialects other than English?

22. Does your organization employ staff fluent in languages or dialects other than English?

23. Does your organization offer written materials in languages other than English?

24. Does your organization do advertising or outreach in languages other than English?

25. How well do you feel that your organization meets the linguistic needs of its clients? Linguistic competency includes language skills (i.e., proficiency in languages other than English) as well as linguistically appropriate service provision (i.e., understanding appropriate terms in ethnic, LGBT, and disability communities, etc.).

26. Please indicate whether you collect demographic data for identified cultural groups.
    - Does your organization collect data on client race/ethnicity?
    - Does your organization collect data on client sex?
    - Does your organization collect data on client gender identity?
    - Does your organization collect data on client sexual orientation?

27. Does your organization have the capacity to do data analysis on the client information it collects?

28. Please describe your community partnerships:
    - Does your organization work with local resource persons to help you better understand beliefs about mental illness in your service community?
    - Has your organization build effective partnerships with local community groups and organizations that serve underserved populations (i.e., social service agencies, faith-based groups, advocacy groups, local business owners)?
    - Does your organization recruit clients or advertise services through community outlets or organizations (i.e., fliers, neighborhood groups, local or specialized newspaper/radio/television programs, business groups, email lists, websites, or Internet resources?)

- Is staff knowledge about appropriate referrals for marginalized populations?
- Do your organization's boards and committees reflect the cultural diversity of your service community?

29. Does your organization solicit community participation in any of the following areas (please check all that apply)?
    - Planning
    - Design
    - Implementation
    - Evaluation
    - Marketing

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CalMHSA

State Hospital Beds

Planning, Development and Operation Cost Projections

County	Bed Count	Billed[1]	Operations	Estimate for Additional Planning & Development 2013-14	Total
Butte	0	-	-	-	-
Contra Costa	0	-	-	-	-
El Dorado	2	568.52	2,719.04	302.12	3,021.16
Fresno	1	284.26	1,359.52	151.06	1,510.58
Kern	8	2,274.08	10,876.16	1,208.48	12,084.64
Kings	1	284.26	1,359.52	151.06	1,510.58
Lake	2	568.52	2,719.04	302.12	3,021.16
Los Angeles	197	55,999.22	267,825.4	29,758.82	297,584.3
Madera	1	284.26	1,359.52	151.06	1,510.58
Marin	4	1,137.04	5,438.08	604.24	6,042.32
Mendocino	1	284.26	1,359.52	151.06	1,510.58
Monterey	4	1,137.04	5,438.08	604.24	6,042.32
Napa	3	852.78	4,078.56	453.18	4,531.74
Nevada	6	1,705.56	8,157.12	906.36	9,063.48
Orange	17	4,832.42	23,111.84	2,568.02	25,679.86
Placer	3	852.78	4,078.56	453.18	4,531.74
Riverside	19	5,400.94	25,830.88	2,870.14	28,701.02
Sacramento	18	5,116.68	24,471.36	2,719.08	27,190.44
San Bernardino	12	3,409.92	16,314.24	1,812.72	18,126.96
San Diego	16	4,548.16	21,752.32	2,416.96	24,169.28
San Joaquin	3	852.78	4,078.56	453.18	4,531.74
Santa Cruz	1	284.26	1,359.52	151.06	1,510.58
Solano	3	852.78	4,078.56	453.18	4,531.74
Stanislaus	3	852.78	4,078.56	453.18	4,531.74
Tulare	6	1,705.50	8,157.12	906.36	9,063.48
TOTAL	**331**	**$94,088.88**	**$450,000**	**$50,000**	**$500,000**

Updated 6/6/13

[1] Represents actual costs through April 30, 2013 and projected through June 30, 2013. Any unspent funds will be carried over and no additional invoicing will occur.

Proposed State Hospital Service Program Administrative and Management Budget

Staffing	Scenarios A Hours (FTE)	B Hours (¾ FTE)	C Hours (½ FTE)	Probable Hours	
Hospital Service Manager	2,080	1,560	1,040	2,080	(FTE)
Accounting	2080	1,560	1,040	1,040	(½ FTE)
Support	2,080	1,560	1,040	1,560	(¾ FTE)
Indirect (5% of time)	+ 312	+ 234	+ 156	+ 234	
	6,552	4,914	3,276	4,914	
Blended Rate Per Hour	x $88	x $88	x $88	x $88	
	$576,576	$432,432	$288,288	$432,432	
Legal Costs	+ 30,000	+ 20,000	+ 12,000	+ 20,000	
	$606,576	**$452,432**	**$300,288**	**$452,432**	
Staffing Cost Per Bed Per Day					
500 Bed Pool	$3.32	$2.47	$1.65	$2.47	
350 Bed Pool	$4.75	$3.54	$2.35	$3.54	

Potential Savings[1]

Cost of Beds (assumed a blended rate of $648 for all bed types)

	Per Day Cost	Annual Cost
500 Beds =	$324,000	$118,260,000
350 Beds =	$226,800	$82,782,000

Utilization Efficiencies Resulting from Fewer Bed Days

(350 beds) % of Beds Reduced	# of Beds Reduced	$ Saved	(500 beds) % of Beds Reduced	# of Beds Reduced	$ Saved
1	3.5	827,820	1	5.0	1,182,600
5	17.5	4,139,100	5	25.0	5,913,000
10	35.0	8,278,200	10	50.0	11,826,000

[1] This does not include additional offset for Medicare as well as bed type utilization.

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REPORT/RECOMMENDATION TO THE BOARD OF SUPERVISORS
OF LOS ANGELES COUNTY, CALIFORNIA
AND RECORD OF ACTION

May 10, 2013

FROM: Marvin Southard, Director
Department of Behavioral Health

SUBJECT: MEMORANDUM OF UNDERSTANDING AND PARTICIPATION WITH CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY OF THE HOSPITAL BED PROGRAM

RECOMMENDATIONS:

Memorandum of Understanding (Agreement No.Click here to enter text.) with the California Mental Health Services Authority (CalMHSA) to provide services. Cost shall be based solely on bed use. The projected per day bed cost is $3.68. Currently Los Angeles County receives 200 beds; therefore the annual budget amount is $269,000 for the period July 1, 2013 through June 30, 2017.

FINANCIAL IMPACT:

Cost Components:

Funding Sources	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Planning and Development	$50,000	0	0	0
Fiscal & Administration Operations	$135,000	$269,000	$269,0000	$269,000
TOTAL	$185,000	$269,000	$269,000	$269,000

The funding source(s) is: ____.

CalMHSA BACKGROUND:

The California Mental Health Services Authority (CalMHSA) is an Independent Administrative and Fiscal Government Agency focused on the efficient delivery of California Mental Health Projects. Member counties jointly develop, fund, and implement mental health services, projects, and educational programs at the state, regional, and local levels.

CalMHSA, a Joint Powers of Authority (JPA), is not a legislative agency, nor an approval or advocacy body. As such, the JPA is a best practice inter-governmental structure with growing capacity and capability to promote systems and services arising from a shared member commitment to community mental health.

Los Angeles County became a member on June 10, 2010 to work collectively to administer the MHSA Statewide funds and explore other opportunities for the betterment of California Mental Health Services in concert with other counties.

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PROGRAM BACKGROUND AND GOALS:

BACKGROUND

At CalMHSA's 2012 Strategic Planning Session, Board members gave staff direction to explore the feasibility of the JPA acting on behalf of member counties in the development of an annual joint purchase agreement with Department of State Hospitals (DSH) for statewide utilization of state hospital beds (as provided under sections 4330 et seq. of the Welfare Institutions Codes (WIC)), and to consider operationalizing certain functions.

Counties and the California Mental Health Directors Association (CMHDA) have had concerns stemming from how the state has handled state hospital bed management in recent years. DSH has demonstrated a lack of compliance with statutory notice periods, third party reimbursement, incomplete information about the setting of rates, challenges in the access to beds paid for by counties, overpayment or duplicate payment of bed days, issues of quality of care, concern about indemnification between the state and counties, and difficulties for county personnel who must conduct oversight on state hospital grounds.

The statutes, referred to above, repeatedly refer to counties contracting in combination with other counties. A county JPA, such as CalMHSA, could be a viable contracting agency for doing so. Counties acting alone have been unsuccessful. Counties contracting together would be more effective in having the state address their other concerns.

The Department of State Hospitals (DSH) increased the average daily bed rate by 28% for FY 2011-12 and FY 2012-13. This trend of cost increases cannot be sustained by counties procuring beds and alternative measures should be considered. Currently Los Angeles County pays nearly $50 million per year for bed use (or on average $648 per day).

DELIVERABLES

Short Term (Step 1): In accordance with the Welfare and Institutions Codes, Counties will come together to act jointly in the contracting with DSH for access and use of state hospital resources, and to ensure compliance with all applicable requirements and provisions of the contract. The intent is for Los Angeles County to be a party to a single joint county Memorandum of Understanding (MOU), with the contracting agency to be CalMHSA and Los Angeles County to have a contract with CalMHSA for its participation in this program.

Short/Medium Term (Step 2): CalMHSA shall serve as the counties' fiscal and administrative agency, and Los Angeles County will participate in the program.

Such fiscal and administrative services include:

A. CONTRACTING

1. Develop new contract terms that address all critical responsibilities, establish performance standards, protect counties from improper inflation of rates, clearly

denote bed classification and processes, and require the state to indemnify counties for liability due to the state's negligent acts.

2. Provide counties the ability to audit DSH costs, appeal DSH decisions, and pursue recourse for unfair dealings by DSH.
3. Develop fair and accurate rates.
4. Enable counties to have more control over realignment funds owed to them. (WIC Section Code 17601)
5. Maximize flexibility of bed utilization.

B. FISCAL

1. Create a baseline to use as a projection of bed use by county and type of bed.
2. Create and maintain an actual cost reimbursement structure. (WIC Section Code 4330)
3. Ensure accuracy of costs charged based on actual use by county and for each bed type.
4. Create a fair and established process for assigning beds.
5. Stabilize and flat line individual county costs.
6. Facilitate an efficient and timely process for invoicing Participants and paying the state.
7. Review excess bed use bills for accuracy.
8. Develop a process for county notification and reconciliation of all third party reimbursements, such as federal reimbursement for services (Medicare).
9. Begin establishment of a database in order to efficiently evaluate DSH and state hospital services and contract compliance, as well as to evaluate alternatives.
10. Use database to enhance bed rate efficiency by bed type.

C. QUALITY OF CARE SERVICES

1. Create a baseline for performance measurements and review for compliance.
2. Provide for regular audits/reviews of performance activity of the counties and Hospitals to ensure expectations are being met.
3. Enhance patient care.
4. Reduce bed use and/or length of stay, leading to less cost.
5. Allow CalMHSA to research options for patient services not provided.

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6. Ensure standardization across the board and creation of a system to measure against.

7. Track services not provided but needed by counties.

8. Allow counties to be more informed and better served, and for DSH to be more informed, resulting in better service to counties. Enhance processes and outcomes.

D. ALTERNATIVES:

1. Determine what services are needed but not provided by DSH.

2. Evaluate alternative treatment providers.

3. Evaluate alternative treatment resources, allowing counties greater control.

E. OTHER OPPORTUNITIES:

1. Develop a list of challenges in the area of care where a collective solution (two or more counties, regionally, or statewide) could benefit the members.

Participating members will benefit from:

A. Joint contract

1. Single voice

2. Leverage in negotiation

3. Contract compliance

B. Contact compliance

1. Performance standards of care

2. Cost reporting and monitoring

3. Hospital and data consistency

4. Admission/access to beds

5. Manage and coordinate the appeals and penalties

6. No mid-year amendment to decrease beds by individual county

7. Compliance with statute

8. Ability to audit DSH records

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C. Potential utilization cost savings

1. Future rate negotiation
2. Bed utilization – move from guaranteed vs. actual use reimbursement
3. Bed placement – savings between bed types and rates
4. Eliminate double charging
5. Assuring reimbursement of credits for Medicare and other third party payers
6. Greater coverage for excess beds

D. Planning and review of alternatives and other related opportunities

E. Collaboration between counties and DSH

F. Creation of data base

G. Demonstration of benefits of counties working jointly

Long Term: Work collectively with other CalMHSA counties in the identification and determination of the feasibility of utilizing alternatives to state hospital resources.

PROGRESS TO DATE:

- Convened the State Hospital Bed Work Group, with Mary Marx, Los Angeles County, as Chair
- Engaged in a joint negotiation with DSH with the intent for one contract/MOU
- Fix the rate for FY 13/14, whereas if the anticipated rate increase was an average of 3%, the rate relief would be greater than $3 million, statewide.
- Attained agreement form Metro State Hospital to provide Intermediate Care Facilities (ICF) beds, which will produce significant savings annually—approximately $1 million per year for Los Angeles County
- Developed a statewide bed pool concept to provide greater utilization and less bed cost (potential savings for Los Angeles County)
- Seeking relief from guarantee of penal code beds
- Designated a point of contact for contract compliance and issues involving care

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MEMORANDUM OF UNDERSTANDING
FOR PROCUREMENT OF STATE HOSPITAL BEDS BETWEEN
CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY
AND
THE COUNTY OF LOS ANGELES COUNTY

July 1, 2014–June 30, 2017

WHEREAS, the County of Los Angeles hereinafter referred to as the County, as a member of the California Mental Health Services Authority, desires to utilize the California Mental Health Services Authority, hereinafter referred to as CalMHSA, to receive necessary services as they pertain to the County's Mental Health Programs; and

WHEREAS, the County has allocated funds from the Click here to enter text. for the following programs: Procurement of State Hospital Beds; and

WHEREAS, the County finds CalMHSA qualified to provide a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts; and

WHEREAS, the County desires that such services be provided by CalMHSA and CalMHSA agrees to perform these services as set forth below; and

NOW THEREFORE, the County and CalMHSA agree to the terms and conditions as described in the attached participation agreement.

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Agreement No. _________

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY
PARTICIPATION AGREEMENT
COVER SHEET

1. ___Los Angeles County_______ ("Participant") desires to participate in the Program identified below.

   Name of Program: ___________Procurement of State Hospital Beds__________________

2. California Mental Health Services Authority ("CalMHSA") and Participant acknowledge that the Program will be governed by CalMHSA's Joint Powers Agreement and its Bylaws, and by the MOU through which non-Members participate. The following exhibits are intended to clarify how the provisions of those documents will be applied to this particular Program.

   ☑ Exhibit A General Program Description
   ☐ Exhibit B Scope of Services
   ☐ Exhibit C Terms and Conditions
   ☐ Exhibit D Budget Detail and Payment Provisions
   ☐ Exhibit E Special Terms and Conditions (optional)

3. The term of the Program is ____7/1/2013______________ through ___6/30/2017___________.

4. Authorized Signatures:

CalMHSA

Signed: _____________________________ Name (Printed): ____________________________

Title: ________________________________ Date: _____________________________________

Participant

Signed: _____________________________ Name (Printed): ____________________________

Title: ________________________________ Date: _____________________________________

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PARTICIPATION AGREEMENT

Exhibit A – General Program Description

I. Recitals

Government Code section 6500 *et seq.* allows California public entities to form separate entities to exercise powers held by its members. California Counties have under the authority of the Government Code formed the California Mental Health Services Authority (CalMHSA). CalMHSA is authorized by its Joint Exercise of Powers Act to jointly develop, and fund mental health services under, among other things, Division 5 of the California Welfare and Institutions Code, including the provision of necessary administrative services.

Sections 4330 through 4335 of the Welfare and Institutions Code provide for Counties, including Counties acting jointly, to contract with the State Department of State Hospitals for use of State Hospital facilities for their civil commitments under Division 5 of the California Welfare and Institutions Code. Certain members of CalMHSA desire to authorize CalMHSA to jointly negotiate and contract with the State Department of State Hospitals for use of such facilities on their behalf.

Under subdivision (b)(1) of Section 17601 of the Welfare and Institutions Code, Cities and Counties must provide reimbursement to the State for their use of State Hospital beds each month; and under subdivision (b)(2) of Section 17601 of the Welfare and Institutions Code, Cities and Counties may annually elect to have the State Controller withhold funds from their State Hospital and Community Mental Health Allocations in order to reimburse the State Hospitals Account for their use of State Hospital beds, in lieu of making payment themselves. CalMHSA members have made no such election for the current fiscal year, and elect to make payment through CalMHSA.

Based on the foregoing, the parties do hereby enter into this Participation Agreement for the CalMHSA State Hospital Bed Program to authorize CalMHSA to contract for State Hospital beds on behalf of Program Participants and to make payment to the State for such usage consistent with the provisions of this Participation Agreement and the MOU to be entered into by CalMHSA and DSH.

II. Name of Program

The CalMHSA State Hospital Bed Program (SHBP).

III. Program Goals

A. CONTRACTING. In accordance with Welfare and Institutions Code section 4330 et seq., Participants will come together to act jointly through CalMHSA in contracting with the California Department of State Hospitals (DSH) for access and use of state hospital bed resources, and to ensure compliance by DSH with all applicable requirements and provisions of CalMHSA's contract with DSH.
B. FISCAL: Work closely with DSH in the analysis of cost containment strategies that create efficiency in the purchasing of state hospital beds and overall cost.

C. QUALITY OF CARE: Work collaboratively with the DSH in establishing "standardization of services" and consistency in services provided to ensure the quality and levels of patient care needed by counties.
D. ALTERNATIVE OPTIONS FOR SERVICES: Work collectively across counties in the identification and determination of the feasibility of utilizing alternatives to state hospital resources.
E. OTHER OPPORTUNITIES: Evaluate collaborative opportunities in the development of programs for special populations requiring secure 24 hour treatment services (i.e., IMD, court commitments, acute treatment, incompetent to stand trial, etc.).

IV. Program Outcomes

As directed by Participants, CalMHSA will collectively work in achieving efficiencies as a single administrative body engaging in a single negotiation of terms and rates for bed utilization, monitor billing to assure accuracy and fiscal stability, establish quality assurance standards and procedures, review shared financial analysis, and explore opportunities and alternatives.

F. CONTRACTING:

2. Develop new contract terms that address all critical responsibilities, establish performance standards, protect counties from improper inflation of rates, clearly denote bed classification and processes, and require the state to indemnify counties for liability due to the state's negligent acts.
3. Provide counties the ability to audit DSH costs, appeal DSH decisions, and pursue recourse for unfair dealings by DSH.
4. Develop fair and accurate rates.
5. Enable counties to have more control over realignment funds owed to them. (WIC Section Code 17601)
6. Maximize flexibility of bed utilization.

G. FISCAL:

1. Create a baseline to use as a projection of bed use by county and type of bed.
2. Create and maintain an actual cost reimbursement structure. (WIC Section Code 4330)
3. Ensure accuracy of costs charged based on actual use by county and for each bed type.
4. Create a fair and established process for assigning beds.
5. Stabilize and flat line individual county costs.
6. Facilitate an efficient and timely process for invoicing Participants and paying the state.
7. Review excess bed use bills for accuracy.
8. Develop a process for county notification and reconciliation of federal reimbursement for services (Medicare).
9. Begin establishment of a database in order to efficiently evaluate DSH and state hospital services and contract compliance, as well as to evaluate alternatives.
10. Use database to enhance bed rate efficiency by bed type.

H. QUALITY OF CARE SERVICES:

1. Create a baseline for performance measurements and review for compliance.

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2. Provide for regular audits/reviews of performance activity of the counties and Hospitals to ensure expectations are being met.
3. Enhance patient care.
4. Reduce bed use and/or length of stay, leading to less cost.
5. Allow CalMHSA to research options for patient services not provided.
6. Ensure standardization across the board and creation of a system to measure against.
7. Track services not provided but needed by counties.
8. Allow counties to be more informed and better served, and for DSH to be more informed, resulting in better service to counties. Enhance processes and outcomes.

I. ALTERNATIVES:

1. Determine what services are needed but not provided by DSH.
2. Evaluate alternative treatment providers.
3. Evaluate alternative treatment resources, allowing counties greater control.

J. OTHER OPPORTUNITIES:

1. Develop a list of challenges in the area of care where a collective solution (two or more counties, regionally, or statewide) could benefit the members.

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PARTICIPATION AGREEMENT

Exhibit B – Scope of Services

I. RELATIONSHIP OF THE PARTIES

Sections 4330 through 4335 of the Welfare and Institutions Code (WIC) require counties to contract with DSH to reimburse DSH for use of state hospital beds/services provided pursuant to Part 1 (commencing with Section 5000) of Division 5 of the WIC. Sections 4330 through 4335 of WIC provide for counties to contract in combination with other counties.

The purpose of this Participation Agreement is to grant CalMHSA the authority to contract with DSH for state hospital bed utilization on behalf of Participants, and to define roles and responsibilities between CalMHSA and Participants in the context of an MOU between CalMHSA and DSH.

Demonstrate and provide proof of authorization to enter into this Agreement on behalf of Participant, consisting of a resolution of Participant's Board authorizing such signature, proof of delegated authority to execute contracts of a class that includes this Participation Agreement, or other comparable authority.

II. GOVERNANCE

A. Per CalMHSA Bylaws, CalMHSA members have the authority to create a Program such as the SHSP, while participants in the SHSP govern its operation through adoption and execution of this Participation Agreement.

B. Participants may determine the need for an oversight committee for this program.

III. GENERAL RESPONSIBILITIES OF PARTIES

A. Responsibilities of CalMHSA

1. Comply with applicable laws, regulations, guidelines, CalMHSA's Joint Powers Agreement, Bylaws, this Participation Agreement, and the Program Bylaws.
2. Provide Participants access to state hospital beds purchased by CalMHSA on behalf of Participants.
3. Use best efforts to obtain an appropriate placement for Participants' patients in a state hospital.
4. Facilitate coordination of treatment and case management by DSH and Participant as to each of Participant's patients.
5. Act as fiscal and administrative agent for Participants in the Program in purchasing state hospital beds at state hospitals from DSH for Lanterman-Petris-Short (LPS) hospital services for those patients referred by Participant for treatment at state hospitals, including those admitted pursuant to Sections 1370.01 of the Penal Code (PC), Murphy Conservatorship (Section 5008(h)(1)(B) of the WIC) and those committed pursuant to provisions of the PC which are converted to LPS billing status.
6. Provide dedicated administrative staff as necessary to perform under this Agreement.
7. Manage funds received through the Program, consistent with the requirements of any applicable laws, regulations, guidelines and/or contractual obligations.

8. Provide regular fiscal and operational reports to Participants and any other public agencies with a right to such reports.
9. Develop allocation model for allocation of beds, funds and expenses among Participants.
10. Facilitate operation of Participant focus groups, training, bed triage process, and dispute resolution process.
11. Credit to account of Participant any financial credits, penalties, payments, offsets, or other receipt of funds attributable to Participants' patient.

B. Responsibilities of Participant

1. Compliance with applicable laws, regulations, guidelines, contractual agreements, joint powers agreements and bylaws.
2. Timely payment, assignment, or other transfer of funds assessed for the Program, consisting of payments toward the pre-payment fund, payments for beds, and any necessary administrative and management costs.
3. Designate CalMHSA as Participant's agent in contracting with DSH for purchase of beds at State Hospitals on behalf of Participant pursuant to WIC 4330 through 4335.
4. Identification of a representative authorized to act for Participant and receive notices on behalf of Participant.
5. Provide input and feedback as necessary to accomplish the purposes of the Program.
6. Timely and complete submission of information in response to requests.
7. Acknowledgement that certain funds contributed by the Participant will be aggregated with the funds of other Participants in the Program, and jointly used to meet the objectives of the Program, pursuant to the allocation formula adopted. Acknowledge that Program expenses will include a proportionate share of CalMHSA's administrative expenses and management costs.
8. Agree to pay for bed/days, and for associated administrative and management costs for Participant's patients upon adoption and approval by the Participants of a budget for administrative costs.

III. SERVICES TO BE CONTRACTED WITH DEPARTMENT OF STATE HOSPITALS AS DETAILED IN THE MOU WITH DSH.

IV. BED USAGE

A. Contracting and Bed Tiers

Based on the contractual commitments made by Participants, through this agreement CalMHSA will contract (MOU) with DSH to provide, within the state hospitals, specific numbers of beds dedicated to the care of those patients referred by CalMHSA Participants, including those admitted pursuant to Section 1370.01 of the Penal Code and Murphy Conservatorships (WIC § 5008(h)(1)(B)) (i.e., Participants' patients).

The number and type of beds for which Participant is committed under this contract are specified in Exhibit B-Attachment. This may include the following tiers of beds.

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a. Beds for which individual Participants have committed (Tier I).
b. Aggregated beds for foreseeable excess use (Tier II).
c. Additional bed/days procured from DSH with Participant authorization (Tier III).

For the purposes of this Agreement the term "committed beds" shall mean that CalMHSA has contracted with DSH to ensure that the number of beds contracted for in a particular cost center category shall be available to Participant at all times for Participant's patients who are appropriate for the services and facilities included in that cost center at the hospital to which the patient is being referred. These shall be Tier I beds.

Tier 1 Beds

Tier I Beds are those bed/types for which a Participant specifically commits, analogous to the commitments made in prior contracts between counties and the California Department of Mental Health (now DSH).

Tier II Beds

Tier II Beds are those bed/types for which CalMHSA contracts with DSH on behalf of those Participants interested in accessing such an aggregate pool. The number of beds contracted for will be calculated based on estimated potential use and each participating Participant billed monthly along with Tier I billing. The calculated amount will be reconciled by CalMHSA with actual usage annually or more often, such that each Participant will only pay for actual usage. Reconciliation would occur within 60 days of the end of the fiscal year and an adjustment will appear in the September billing.

Tier II Beds

Tier III Beds describes a pre-funding mechanism for those Participants who are interested in such pre-funding, the amount of which will be calculated based on estimated or projected use of bed/days in excess of Tiers I and II. The pre-fund calculation will be provided to Participants by June 1 annually, with interested Participants contributing by July 31 each year. Tier III expenditures will be reconciled at the end of each fiscal year.

B. Exceeding Contracted Capacity

Participant shall be considered to have exceeded its committed capacity on any given day on which more Participant patients are assigned to a cost center than the Participant has contracted for Tier 1 beds or available in Tier II beds on a pooling basis. Participant shall be permitted to use beds in excess of Tier I and Tier II capacity when use does not result in denial of access of other counties to their dedicated capacity. CalMHSA shall attempt to obtain placement for Participant's patients on an excess basis within one week of notice. Participant's use in excess of the Agreement amount shall be calculated as provided in Exhibit B-Attachment.

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CalMHSA shall review Participant's use of state hospital beds on a monthly basis to determine if the dollar value of Participant's use has exceeded the dollar value of Participant's contracted beds under this Agreement. Excess use shall be established when the net dollar value of Participant's actual use exceeds the contracted amount for the period under consideration. Participant shall be obligated to pay the contract amount for the period or the dollar value of Participant's actual use for the period, whichever is greater.

C. Participant's Financial Commitment

So that no Participant shall be obligated beyond its commitment, no one Participant's maximum obligation shall be reduced below the contract amount set forth in Exhibit B-Attachment.

A Participant that has not committed to any state hospital bed/years shall be financially responsible for its use of state hospital resources resulting from, but not limited to, the conversion of Penal Code commitments to Murphy Conservatorships (WIC § 5008(h)(1)(8)).

There shall be no decrease in the number of beds contracted for by Participant within the state hospitals and within a cost center, unless this Agreement is amended by mutual agreement not later than January 1 of the fiscal year. (WIC § 4331(b)(3).)

When Participant has a patient at a hospital other than at its primary use LPS hospital, CalMHSA shall use one of Participant's vacant dedicated beds, in an equivalent cost center at its primary use LPS hospital, to cover the costs of that patient's care. If Participant has no available dedicated capacity, it shall obtain the required capacity by purchasing it from CalMHSA or directly from DSH.

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PARTICIPATION AGREEMENT

Exhibit C - General Terms and Conditions

I. Definitions

Throughout this Participation Agreement, the following terms are defined as follows:

A. CalMHSA - California Mental Health Services Authority, a Joint Powers Authority created to jointly develop and fund mental health services and education programs for its Member Counties and Partner Counties.

B. Department of Health Care Services (DHCS) - The California Department of Health Care Services.

C. Department of State Hospitals (DSH) – The California Department of State Hospitals

D. Member – refers to a County (or JPA of two or more Counties) that has joined CalMHSA and executed the CalMHSA Joint Powers Agreement.

E. Mental Health Services Act (MHSA) – Initially known as Proposition 63 in the November 2004 election, which added sections to the Welfare and Institutions Code providing for, among other things, PEI Programs.

F. Mental Health Services Oversight and Accountability Commission (OAC) - The oversight body to ensure the activities are in accordance with the Mental Health Services Act.

G. Partner - A non-Member County (or multi-county JPA) participating in a Program with CalMHSA Members.

H. Participant– Counties participating in the Program either as Members of CalMHSA or as Partners under a Memorandum of Understanding with CalMHSA.

I. Program – The program identified in the Cover Sheet.

II. Responsibilities

A. Responsibilities of CalMHSA:

1. Develop Program plan, updates, and/or work plans as necessary on behalf of and in coordination with Participants that are consistent with applicable laws, regulations, guidelines and/or contractual obligations. These may include, but are not limited to, obligations imposed by DHCS and/or OAC.

2. Act as fiscal and administrative agent for Participants in the Program.

3. Directly or indirectly (through a contracted JPA Management firm) hire and employ Program Directors and other administrative staff as necessary to perform under this Memorandum.

4. Submission of plans, updates, and/or work plans on behalf of and/or in coordination with Participants for review and approval by any public agency with authority over the Program.

5. Management of funds received the Program consistent with the requirements of any applicable laws, regulations, guidelines and/or contractual obligations.

6. Provide regular fiscal reports to Participants and/or other public agencies with a right to such reports.

7. Develop allocation model for allocation of funds and expenses among Participants, years, and Programs.

8. Compliance with CalMHSA's Joint Powers Agreement and Bylaws.

C. Responsibilities of Participants:

1. Timely assignment of funds assessed for the Participating Program.

2. Identification of a representative authorized to act for Participant and receive notices on behalf of Participant. Identification of an alternate to attend meetings in absence of representative.

3. Attend advisory committee meetings for the Program, and provide input as necessary to accomplish the purposes of the Program.

4. Cooperate by providing CalMHSA with requested information and assistance in order to fulfill the purpose of the Program.

5. Provide feedback on Program performance.

6. Timely and complete submission in response to requests for information and items needed.

7. Acknowledgement that funds contributed by the Participant will be pooled with the funds of other Participants in the Program, and jointly used to meet the objectives of the Program, pursuant to the allocation formula adopted for the Program. Program expenses will normally include a proportionate share of CalMHSA's general administrative expenses, since there is no independent source of funding for such expenses.

8. Compliance with applicable laws, regulations, guidelines, contractual agreements, joint powers agreements and bylaws.

III. Duration and Term

A. The term of the Program is as shown on the Cover Sheet. The Program may be extended or terminated early depending on the availability of funds.

B. Any Participant may withdraw from the Program upon six months written notice. Notice shall be deemed served on the date of mailing.

C. The majority of the Participants may vote to expel a Participant from the Program for cause. Cause shall be defined as any breach of this Participation Agreement, any misrepresentation, or fraud on the part of any Participant.

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IV. Withdrawal, Cancellation and Termination

A. The withdrawal of a Participant from the Program shall not automatically terminate its responsibility for its share of the expenses and liabilities of the Program. The contributions of current and past Participants are chargeable for their respective share of unavoidable expenses and liabilities arising during the period of their participation

B. Upon cancellation, termination or other conclusion of the Program, any funds remaining undisbursed after CalMHSA satisfies all obligations arising from the operation of the Program shall be distributed and apportioned among the Participants in proportion to their contributions.

V. Fiscal Provisions

A. Funding required from the Participants will not exceed the amount stated in the Cover Sheet.

B. Participants will share in the costs of planning, administration and evaluation in the same proportions as their overall contributions, which are included in the amount stated on the Cover Sheet.

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PARTICIPATION AGREEMENT

EXHIBIT D - BUDGET DETAIL AND PAYMENT PROVISIONS

STATE HOSPITAL BED PURCHASE AND USAGE

I. CONTRACT AMOUNT AND PAYMENT PROVISIONS

The amount payable by Participant to CalMHSA concerning all aspects of this Agreement shall be $_____________, the maximum obligation as approved by the participant. The amount reflected here was computed based on the information contained in the Exhibit B-Attachment. The amount represents the application of the State Hospital Rates for the Fiscal Year as published by DSH, which by this reference is made a part hereof, to Participant's contracted beds. In addition, this amount includes an administrative charge assessed on the number of contracted beds listed in Exhibit B-Attachment, based the SHSP administrative budget adopted for the fiscal year by the Participants.

Any Participant bed use in excess of the contracted amount, as defined in Exhibit B, Section IV., Bed Usage, during the fiscal year, shall be an additional financial obligation to Participant.

Prepayment and funding process will be electronic with a completed form attached. All submissions shall be reviewed by the Bed Pool Manager (BPM).

Tier I Beds

Participant shall provide to CalMHSA the number of beds they want to obligate to by December 31st, six months prior to end of the fiscal year. CalMHSA shall make the necessary computation based on the obligation of December 31st by bed type and rate to determine the Participants obligation amount.

Upon determination, notice will be sent to the Participant, annually by June 1st. Participants shall pay CalMHSA by the 15th of each month commencing July 15th.

Tier II Beds

CalMHSA will make computations for the projected aggregated obligation, based on historical use. This total shall be reduced by Tier I beds and adjusted for potential decrease in use. This computation will added to the MOU with DSH, along with Tier I computation.

Computation will be reconciled (obligation vs. used) annually such that Participant will only pay for actual use. This is to be provided within 60 days of each year-end and any adjustments shall be provided in the September invoice.

Tier III Beds

CalMHSA shall be the point agency to procure excess beds not obligated by the Participant or CalMHSA (i.e. Tier I or II Beds). A pre-fund computation will be established and provided to Participant by June 1st

annually. Participant shall contribute to this pre-fund by July 31st annually. This obligation will be reconciled a year-end for the subsequent years Pre-Fund.

DSH shall invoice CalMHSA monthly for actual bed use. CalMHSA will make the computation of actual use for the Participant, for that month. A single invoice shall be issued to the Participant with reimbursement to CalMHSA within 30 days. CalMHSA shall make payment to DSH in accordance with the MOU.

II. BUDGET CONTINGENCIES

This Agreement is subject to any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act or any statute enacted by the Legislature which may affect the provisions, terms, or funding of this Agreement in any manner. If statutory or regulatory changes occur during the term of this Agreement, both parties may renegotiate the terms of the Agreement affected by the statutory or regulatory changes.

This Agreement may be amended only in writing upon mutual consent of the parties. A duly authorized representative of each party shall execute such amendments.

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California Mental Health Services Authority

STRATEGIC PLANNING FRAMEWORK

Methodologies

Examples of methodologies for determining the statewide projects to be funded or sustained:

1. Value of Statewide-ness (building a case for local stakeholders)
    a. Cost/benefit scale
    b. Public health approach
    c. National model
    d. Long-term impact
2. Performance to date
3. Evidence of impact to date
4. Adverse consequence if discontinued

Principles

Inclusion of principles adopted in the current plan? Such as:

1. Maintain overall consistency in the proportion of funds allocated to Suicide Prevention (25%); Stigma and Discrimination Reduction (37.5%); and Student Mental Health (37.5%).
2. Strengthen local and regional capacity by ensuring new CalMHSA participants are included in funded activities.
3. Strengthen racial, ethnic and cultural competency within existing projects.
4. Implement PEI projects in an expeditious manner.
5. Expand the scope of regional projects to include additional geographic areas and underserved populations.
6. Consider the unique characteristics of communities participating in CalMHSA, including local factors such as capacity, population, and setting (rural, suburban, urban).
7. Consider performance, sustainability and leveraging opportunities to maximize available funding.
8. Enhance capacity for data-driven decision making and contribute to the body of knowledge of emerging PEI best practices to improve student mental health, prevent suicide and reduce stigma and resulting discrimination.

Project Identification

Criteria for selection of projects might include:

- Currently funded projects
- SP and SDR Strategic Plans (projects not yet funded)
- Regional/statewide gaps

Budgets (Possible Scenarios)

- All counties assign a percent of local PEI dollars
- Possible minimum threshold based on county size
- Other formula

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STATEWIDE PEI
PROPOSED STRATEGIC PLANNING PROCESS AND TIMELINE
April 1, 2013 – June 30, 2017

Date		Task	Action	Presented to	Responsible
2013 (CalMHSA Process)	April	▪ Propose strategic planning process and timeline ▪ Present Framework Strategic Plan	▪ Review, edit and recommend for approval	▪ Board of Directors *(April 12, 2013)*	▪ Board of Directors
	May	▪ Present Draft Strategic Plan elements – ▪ Principles ▪ Methodologies	▪ Convene Board Workgroup ▪ Identify sustainability options and projected funding need from counties ▪ Recommend and approve principles for identification of statewide initiatives	▪ Advisory Committee *(May 9, 2013)* ▪ Executive Committee *(May 22, 2013)*	▪ Executive Committee ▪ Board of Directors ▪ Staff
	June			▪ Board of Directors *(June 13, 2013)*	
	July	▪ RAND preliminary findings report released – apply data to county/region/statewide impact	▪ Review preliminary report	▪ SEE Team *(July 2013)* ▪ Board Workgroup feedback ▪ Advisory Committee feedback (July 11, 2013)	▪ Staff ▪ Executive Committee ▪ Board of Directors
	August	▪ Present updated Draft Strategic Plan – Version #1 ▪ Proposed initiatives for continuation ▪ Other funding (as applicable) ▪ Three tiers based on project funding levels (100%/75%/50%)	▪ Recommend and approve proposed compilation of recommendations for continuing initiatives for Executive Committee (late July) ▪ Develop tiered cost projects for sustaining statewide initiatives ▪ Financing projects ▪ Budget development begins	▪ Executive Committee *(July 25, 2013)* ▪ Board of Directors *(August 15, 2013)* ▪ **Local MHSA Stakeholders**	▪ Staff ▪ Workgroup ▪ Executive Committee ▪ Finance Committee ▪ County MHSA Staff and MH Director
	September October	▪ Present Updated Draft Strategic Plan—Version #2	▪ Identify new initiatives (as applicable) ▪ Increase release of information to counties regarding continuing initiative using RAND data from July report, distribute to CalMHSA members in October as part of county Return on Investment (ROI)	▪ Advisory Committee *(September 12, 2013)* ▪ Board of Directors *(October 10, 2013)* ▪ **Local MHSA Stakeholders**	▪ Staff ▪ Workgroup ▪ Executive Committee ▪ County MHSA Staff and MH Director

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STATEWIDE PEI
PROPOSED STRATEGIC PLANNING PROCESS AND TIMELINE
April 1, 2013 – June 30, 2017

Date		Task	Action	Presented to	Responsible
	November December	▪ Present Final Strategic Plan– ▪ Revised recommendations ▪ Funding for new statewide initiatives proposals for stakeholder review	▪ Recommend and approve Final Strategic Plan ▪ PEI budget presented	▪ Advisory Committee *(November 15, 2013)* ▪ Board of Directors *(December 12, 2013)* ▪ **Local MHSA Stakeholders**	▪ Staff ▪ Workgroup ▪ County MHSA staff and MH Director ▪ Finance Committee

COMPONENTS – BRIEF SUMMARY

JPA

- Develop process and methodology for identification of which initiatives to continue in FY 14-15 and beyond
- Develop and approve cost schedule and funding for initiatives
- Approval of cost allocation method to counties
  - Tiered plan for consideration that not all counties may want to participate at the same level
- Release of information to Counties
  - Return on Investment (ROI) by county
  - RAND preliminary findings report
  - Clear rationale for each initiative
- Develop internal process to bring new project ideas to CalMHSA for consideration
  - Identify new initiatives for JPA
  - Identify additional funding sources (grants, etc.)

Counties

- Take MHSA statewide initiative proposal to stakeholders
- Approval by Mental Health Boards and Board of Supervisors (BOS) (timeline based on individual County process)
- Allocating MHSA funds to CalMHSA via agreement

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Preliminary Allocation Based on PEI Assignments
June 2013 Version*

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Partipating Counties by Region

By Region	Current Planning Dollars	Current Assigned Program Dollars	Total Assigned Dollars	% of Region	% Overall Dollars	% of Member Dollars	Future Dollars*	
Bay Area Region - Assigned							$20,000,000	
			Program Dollars				All Counties	Members
Alameda	72,875	5,757,125	5,830,000	18.65%	3.64%	3.66%	728,750	731,231
Berkeley City	6,395	505,205	511,600	1.64%	0.32%	0.32%	63,950	64,168
Contra Costa	183,440	3,485,360	3,668,800	11.73%	2.29%	2.30%	458,600	460,161
Marin	44,480	845,120	889,600	2.85%	0.56%	0.56%	111,200	111,579
Monterey	91,320	1,735,080	1,826,400	5.84%	1.14%	1.15%	228,300	229,077
Napa	24,220	460,180	484,400	1.55%	0.30%	0.30%	60,550	60,756
San Benito	2,770	218,830	221,600	0.71%	0.14%	0.14%	27,700	27,794
San Francisco	151,020	2,869,380	3,020,400	9.66%	1.89%	1.89%	377,550	378,835
San Mateo	130,540	2,480,260	2,610,800	8.35%	1.63%	1.64%	326,350	327,461
Santa Clara	385,380	7,322,220	7,707,600	24.65%	4.82%	4.83%	963,450	966,730
Santa Cruz	56,500	1,073,500	1,130,000	3.61%	0.71%	0.71%	141,250	141,731
Solano	80,220	1,524,180	1,604,400	5.13%	1.00%	1.01%	200,550	201,233
Sonoma	87,940	1,670,860	1,758,800	5.63%	1.10%	1.10%	219,850	220,598
Total Region	1,317,100	29,947,300	31,264,400	100.00%	19.54%	19.61%	3,908,050	3,921,353
Central Region								
Amador	6,320	120,080	126,400	0.57%	0.08%	0.08%	15,800	15,854
Calaveras	2,065	163,135	165,200	0.74%	0.10%	0.10%	20,650	20,720
El Dorado	29,040	551,760	580,800	2.61%	0.36%	0.36%	72,600	72,847
Fresno	199,700	3,794,300	3,994,000	17.95%	2.50%	2.50%	499,250	500,949
Inyo	1,250	98,750	100,000	0.45%	0.06%	0.06%	12,500	12,543
Kings	7,500	592,500	600,000	2.70%	0.38%	0.38%	75,000	75,255
Mariposa	1,250	98,750	100,000	0.45%	0.06%	0.06%	12,500	12,543
Madera	32,480	617,120	649,600	2.92%	0.41%	0.41%	81,200	81,476
Merced	56,640	1,076,160	1,132,800	5.09%	0.71%	0.71%	141,600	142,082
Mono	1,250	98,750	100,000	0.45%	0.06%	0.06%	12,500	12,543
Placer	54,820	1,041,580	1,096,400	4.93%	0.69%	0.69%	137,050	137,517
Sacramento	266,360	5,060,840	5,327,200	23.95%	3.33%	3.34%	665,900	668,167
San Joaquin	33,475	2,644,525	2,678,000	12.04%	1.67%	1.68%	334,750	335,890
Stanislaus	102,040	1,938,760	2,040,800	9.17%	1.28%	1.28%	255,100	255,968
Sutter/Yuba	30,040	570,760	600,800	2.70%	0.38%	0.38%	75,100	75,356
Tulare	2,415	190,785	193,200	0.87%	0.12%	0.12%	24,150	24,232
Tuolumne	24,105	1,904,295	1,928,400	8.67%	1.21%	1.21%	241,050	241,871
Yolo	41,640	791,160	832,800	3.74%	0.52%	0.52%	104,100	104,454
Total Region	892,390	21,354,010	22,246,400	100.00%	13.90%	13.95%	2,780,800	2,790,266
Los Angeles Region								
Los Angeles	2,335,680	44,377,920	46,713,600	100.00%	29.20%	29.30%	5,839,200	5,859,077
Southern Region								
Imperial	37,500	712,500	750,000	1.35%	0.47%	0.47%	93,750	94,069
Kern	171,180	3,252,420	3,423,600	6.17%	2.14%	2.15%	427,950	429,407
Orange	666,840	12,669,960	13,336,800	24.04%	8.34%	8.36%	1,667,100	1,672,775
Riverside	442,800	8,413,200	8,856,000	15.96%	5.54%	5.55%	1,107,000	1,110,768
San Bernardino	430,760	8,184,440	8,615,200	15.53%	5.38%	5.40%	1,076,900	1,080,566
San Diego	675,340	12,831,460	13,506,800	24.34%	8.44%	8.47%	1,688,350	1,694,097
San Luis Obispo	51,600	980,400	1,032,000	1.86%	0.65%	0.65%	129,000	129,439
Santa Barbara	90,440	1,718,360	1,808,800	3.26%	1.13%	1.13%	226,100	226,870
Tri-Cities	10,215	806,985	817,200	1.47%	0.51%	0.51%	102,150	102,498
Ventura	166,960	3,172,240	3,339,200	6.02%	2.09%	2.09%	417,400	418,821
Total Region	2,743,635	52,741,965	55,485,600	100.00%	34.68%	34.80%	6,935,700	6,959,309
Superior Region								
Butte	43,760	831,440	875,200	23.36%	0.55%	0.55%	109,400	109,772
Colusa	5,000	95,000	100,000	2.67%	0.06%	0.06%	12,500	12,543
Del Norte	1,265	99,935	101,200	2.70%	0.06%	0.06%	12,650	12,693
Glenn	5,420	102,980	108,400	2.89%	0.07%	0.07%	13,550	13,596
Humboldt	25,140	477,660	502,800	13.42%	0.31%	0.32%	62,850	63,064
Lake	11,840	224,960	236,800	6.32%	0.15%	0.15%	29,600	29,701
Lassen	1,265	99,935	101,200	2.70%	0.06%	0.06%	12,650	12,693
Mendocino	16,400	311,600	328,000	8.75%	0.21%	0.21%	41,000	41,140
Modoc	5,000	95,000	100,000	2.67%	0.06%	0.06%	12,500	12,543
Nevada	4,325	341,675	346,000	9.23%	0.22%	0.22%	43,250	43,397
Shasta	8,805	695,595	704,400	18.80%	0.44%	0.44%	88,050	88,350
Siskiyou	7,160	136,040	143,200	3.82%	0.09%	0.09%	17,900	17,961
Trinity	5,000	95,000	100,000	2.67%	0.06%	0.06%	12,500	12,543
Total Region	140,380	3,606,820	3,747,200	100.00%	2.34%	2.35%	468,400	469,994
TOTAL	7,429,185	152,028,015	159,457,200		99.66%	100.00%	19,932,150	20,000,000

* This is based on projected annual budget of $20 million. Current Workplan annaul cost is approximately $40 million.

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Preliminary Allocation Based on PEI Assignments
June 2013 Version*

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Non Partipating Counties by Region

By Region	Current Planning Dollars	Current Assigned Program Dollars	Total Assigned Dollars	% of Region	% Overall Dollars	% of Non Member Dollars	
Bay Area Region - Full Participation							
Central Region							
Alpine	**1,250**	**98,750**	**100,000**	**100.00%**	**0.06%**	**18.42%**	12,500
Total Region	**1,250**	**98,750**	**100,000**	**100.00%**	**0.06%**	**18.42%**	12,500
Los Angeles Region - Full Participation							
Southern Region - Full Participation							
Superior Region							
Plumas	**1,250**	**98,750**	**100,000**	**22.58%**	**0.06%**	**18.42%**	12,500
Sierra	**1,250**	**98,750**	**100,000**	**22.58%**	**0.06%**	**18.42%**	12,500
Tehama	**3,035**	**239,765**	**242,800**	**54.83%**	**0.15%**	**44.73%**	30,350
Total Region	**5,535**	**437,265**	**442,800**	**100.00%**	**0.28%**	**81.58%**	55,350
Total Non Participating	**6,785**	**536,015**	**542,800**		**0.34%**	**100.00%**	**67,850**
Total Statewide	**7,435,970**	**152,564,030**	**160,000,000**		**100%**		**20,000,000**

Population Information provided by California Department of Finance, Updated January 2009

* **This is based on projected annual budget of $20 million. Current Workplan annaul cost is approximately $40 million.**