

Board of Directors Meeting

AGENDA

September 10, 2010

8:30 a.m. – 12 p.m.



Meeting Location:

California Institute for Mental Health (CiMH)
2125 19th Street, 2nd Floor
Sacramento, CA 95818
(916) 556-3480

California Mental Health Service Authority

(CalMHSA)

Board of Directors Meeting

Agenda

Friday, September 10, 2010

8:30 a.m. – 12 p.m.

California Institute for Mental Health (CiMH)

2125 19th Street, 2nd Floor

Sacramento, CA 95818

(916) 556-3480

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 Kim Santin at (916) 859-4820 (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.

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. Comments will be limited to three minutes per person and twenty 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.

4. APPROVAL OF AGENDA AS POSTED (OR AMENDED)

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

- A. Minutes from the August 12, 2010 Board of Director’s Meeting 6
- B. Mark Refowitz, MSW, Orange County appointed as Southern Area Regional Representative
- C. CalMHSA Membership and Outreach Documents 21
- D. First PEI Assignment Dollars from the Department of Mental Health 23
- E. CalMHSA County PEI Assignment(s) Status 24
- F. California Institute for Mental Health (CiMH) - Technical Assistance and Capacity Building

Recommendation: Staff recommends the Board formally consider approval of the Consent Calendar.

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6. NEW COUNTY MEMBERSHIP APPLICATION(S)	
A. CalMHSA New County Membership Application(s) Recommendation: Approve membership to CalMHSA for applying County(ies).	32
7. PROGRAM MATTERS	
A. Report from CalMHSA Program Director – Edward Walker Recommendation: Approval of the proposed ad hoc committee recommendations regarding the following: i. Implementation Timeline ii. Priority of Recommended Actions	33
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A. CalMHSA Bylaws Recommendation: Staff recommends that the Board approve the proposed amendment of the Bylaws.	89
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A. Report from CalMHSA Executive Director – John Chaquica Recommendation: For discussion and/or action should action be deemed appropriate.	111

10. 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 twenty minutes in total. The Board may also limit public comment time regarding agenda items, if necessary, due to a lengthy agenda.

B. Stakeholder Non-Agenda Items

This time is reserved for members of the public to address the Board relative to matters of the 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 twenty minutes in total.

11. NEW BUSINESS

- A. General Discussion Regarding any New Business Topics for Future Meetings

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

- A. Board
- B. Staff

13. ADJOURNMENT

Notice: The next Board of Directors Meeting is scheduled for Thursday, October 14, 2010 from 2:45 p.m. to 5:00 p.m. at the Marriott Courtyard, 1782 Tribute Road, Sacramento, CA 95815.

CONSENT CALENDAR

Agenda Item 5

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. Minutes from the August 12, 2010 Board of Directors Meeting
- B. Mark Refowitz, MSW, Orange County appointed as Southern Area Regional Representative
- C. CalMHSA Membership and Outreach Documents
- D. First PEI Assignment Dollars from the Department of Mental Health
- E. CalMHSA County PEI Assignment(s) Status
- F. California Institute for Mental Health (CiMH) - Technical Assistance and Capacity Building

RECOMMENDATION:

Staff recommends the Board formally consider approval of the Consent Calendar.

REFERENCE MATERIALS ATTACHED:

- Minutes from the August 10, 2010 Board of Directors Meeting
- CalMHSA Membership Roster
- Categorized County Outreach
- First PEI Assignment checks from the Department of Mental Health
- CalMHSA PEI Spreadsheet
- DMH PEI Spreadsheet
- CiMH - Technical Assistance and Capacity Building *(to follow under separate cover)*

MINUTES

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

BOARD OF DIRECTORS MEETING – REGULAR MEETING

Double Tree Hotel

August 12, 2010

MEMBERS PRESENT

Allan Rawland, MSW, ACSW, CalMHSA President, San Bernardino County

Wayne Clark, PhD, CalMHSA Vice-President, Monterey County

Karen Baylor, PhD, MFT, CalMHSA Treasurer, San Luis Obispo County

Maureen Bauman, LCSW, CalMHSA Secretary, Placer County

Brad Luz, PhD, Sutter/Yuba County

William Arroyo, MD, Los Angeles County (alternate)

Madelyn Schlaepfer, PhD, Stanislaus County (alternate)

Scott Gruendl, MPA, Glenn County

Mary Ann Bennett, Sacramento County

Anne Robin, MFT, Butte County

Noel J. O'Neill, MFT, Trinity County

Glenda Lingenfelter, RN, Solano County

Karen Stockton, PhD, MSW, Modoc County

Bruce Gurganus, MFT, Marin County (Membership approved in agenda item 7)

Mark Refowitz, MSW, Orange County (Membership approved in agenda item 7)

Joan Beesley, Yolo County, (alternate), (Membership approved in agenda item 7)

NON-VOTING ALTERNATE

Tom Sherry, MFT, Sutter/Yuba County (alternate)

MEMBERS ABSENT

Leslie Tremaine, EdD, Santa Cruz County

William Cornelius, PhD, Colusa County

Denise Hunt, MFT, Stanislaus County

STAFF PRESENT

John Chaquica, CPA, MBA, ARM, CalMHSA Executive Director

Kim Santin, CPA, CalMHSA Finance and Administration Director

Edward Walker, LCSW, CalMHSA Program Director

Laura Li, CalMHSA Program Executive Assistant

Maya Maas, CalMHSA Executive Assistant

Doug Alliston, Legal Counsel

MEMBERS OF THE PUBLIC

Asha George, Humboldt County

Stephanie Welch, California Mental Health Directors Association (CMHDA)

David Kopperud, California Department of Education

Lin Benjamin, California Department of Aging

Monica Nepomuceno, California Department of Education

Betsy Sheldon, California Community Colleges, Chancellor's Office

Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)

Ann Arneill-Py, California Mental Health Planning Council

Zoey Todd, California Department of Mental Health (DMH)

Ann Collentine, Mental Health Service Oversight and Accountability Commission (MHSOAC)

Pat Ryan, California Mental Health Directors Association (CMHDA)

Karolyn Stein, Humboldt County

Enrica Bertoldo, Mental Health Service Oversight and Accountability Commission (MHSOAC)

Desiree Alarcon, CA Youth Empowerment Network (CAYEN)

Amber Burkan, CA Youth Empowerment Network (CAYEN)

Delphine Brody, California Network of Mental Health Clients (CNMHC)

Viviana Criado, California Elder Mental Health and Aging Coalition (CEMHAC)

Sandra Naylor Goodwin, California Institute Mental Health (CiMH)

Alfredo Aguirre, San Diego County

Janet Fricke, Governor's Committee

Michael Lucid, Sonoma County Mental Health

Derrick West, Sonoma County Mental Health

Scott Rose, Runyon Saltzman & Einhorn

Kathleen Derby, National Alliance of Mental Health (NAMI California)

1. CALL TO ORDER

CalMHSA Board President, Mr. Allan Rawland, called the meeting to order at 2:45 pm.

2. INTRODUCTIONS

President Rawland requested that Ms. Li, CalMHSA Administrative Staff, proceeded with taking roll. After confirmation of a quorum each County present introduced themselves as well as the members of the public.

3. PUBLIC COMMENTS

President Rawland explained the process then asked for public comment.

Delphine Brody, CNMMC, stated that she had concerns with CalMHSA having an Ad Hoc Committee meeting on July 27th, which was not publically noted and stated that she would like to attend all of these meetings and would appreciate the Board's consideration in opening these meetings for stakeholders to attend.

Doug Alliston, Legal Counsel, clarified that the ad hoc committee is strictly advisory, composed of less than a quorum of the Board, and has a limited purpose, so that it is not subject to the Brown Act and posting is not required.

Stacie Hiramoto, REMHDCO, echoed Ms. Brody's concerns and added that although CalMHSA was in compliance with the law, they would very much appreciate the duplicating of the OAC's procedures of allowing stakeholders to partake in all of their planning meetings, to the point that they were allowed to provide input for OAC planning meeting agendas.

Karolyn Stein, Humboldt County, stated they had concerns with one of the clauses in Article 16 of the JPA Agreement. Ms. Stein asked if members given authority (by their BOS) to sign the original agreement had to return to their perspective boards to obtain approval on the amended JPA Agreement? She also asked where CalMHSA was in ratifying the revised JPA Agreement.

Mr. Alliston noted there were draft agreements as early as 2008 and a proto-draft agreement (which he received from Humboldt County) dated March 2009, which is slightly different from the July 2009 Agreement. He added there were additional amendments to the JPA Agreement which were approved in June 2010 and unless members received previous BOS approval to allow directors to sign all future documents pertaining to the agreement, then they will be required to go back to their BOS for approval of the amendments.

President Rawland explained the second agreement is basically an amendment to the original agreement and he is going before his BOS within a couple of weeks to get approval of the amendments.

John Chaquica, CalMHSA Executive Director, confirmed staff would prepare an inventory of signatures and agreements for the next board meeting.

President Rawland asked Ms. Stein if she was comfortable with the above responses, to which she responded in the affirmative.

4. BOARD OF DIRECTORS STUDY SESSION

Mr. Alliston, lead the Board in a study session regarding Closed Sessions as it relates to the Brown Act.

5. APPROVAL OF AGENDA AS POSTED (OR AMENDED)

President Rawland asked if there was any comment from the Board or Public as it relates to the posted agenda, no comments were raised.

A motion was made to approve the agenda as posted.

Motion: Wayne Clark, PhD, Monterey County

Second: William Arroyo, MD, Los Angeles County

The motion carried unanimously.

6. CONSENT CALENDAR

- A. Minutes from the July 15, 2010, Board of Director's Meeting
- B. Memorandum of Understanding (MOU) between CalMHSA and Non-Member Counties.

President Rawland asked if any member of the Board or public had questions/concerns that they wanted to raise regarding the above items. No comment was made by either Board Members or Public.

A motion was made to approve the items on the Consent Calendar.

Motion: Karen Stockton, PhD, MSW, Modoc County

Second: William Arroyo, MD, Los Angeles County

The motion carried unanimously.

7. NEW MEMBER OUTREACH/DEVELOPMENT

A. CalMHSA New County Membership Applications (s)

Edward Walker, CalMHSA Program Director, addressed the Board and stated they had before them three applications for approval from Orange, Marin and Yolo counties.

A motion was made to approve the applications from Orange, Marin and Yolo counties.

Motion: Noel O’Neill, MFT, Trinity County

Second: Wayne Clark, PhD, Monterey County

The motion carried unanimously.

After Board approval, CalMHSA Board Treasurer, Dr. Karen Baylor distributed welcome packets and CalMHSA pins to new members.

B. Regional Representatives – Membership Development and Member Support

Mr. Walker reported that as previously directed by the Board, page 46 of the agenda identifies the Regional Representatives as well as the roles and responsibilities of those representatives.

No action was required as it was an information item only.

C. CalMHSA Membership and PEI Assignment Status

Mr. Walker reported that the report from the previous meeting was substantially the same and Ms. Li continues to prepare an end of the week report on county outreach and member activities. Mr. Walker added that he would be meeting with San Francisco and Alameda counties the following day to discuss the JPA. El Dorado and Ventura counties are going through their administrative process as well.

Ms. Li added that it was expected that one or two counties would be on the September agenda for approval.

Scott Gruendl, MPA, Glenn County, mentioned that he, Mr. Walker, Dr. Stockton, Modoc County and Noel O'Neill, Trinity County, had been working closely with the Regional Council of Rural Counties (RCRC) staff to assist in preparing a position paper as to why counties should join the JPA.

President Rawland expressed that a Southern Regional Representative from the Board, that sits on the Executive Committee needed to be appointed. He added that the Executive Committee would become more important as to operational business moving forward.

With no objection from the Board, President Rawland appointed Mark Refowitz, Orange County, as the Southern Regional Representative.

Mr. Chaquica conveyed staff continuously updates the Membership and PEI documents as it's critical for the JPA, including the ongoing collaboration with DMH and MHSOAC which allows for appropriate follow through in regards to county concerns and questions. Additionally, Mr. Chaquica explained the categorized outreach sheet on page 51 of the agenda, suggesting that if List A of the Outreach joined the JPA, then CalMHSA would be at 80% of the population, which is very encouraging.

Kim Santin, CalMHSA Finance and Administration Director, reported to date three checks had been received, from the State, totaling \$244,020.00. The checks reflect assignments from the following six counties: Butte, Monterey, Santa Cruz, Solano, Stanislaus and Trinity.

Ms. Santin added accounts receivables would start being recorded on the balance sheet and transfers made to the CalMHSA LAIF account.

8. ADMINISTRATIVE MATTERS

A. CalMHSA Vision and Purpose Statements

Mr. Chaquica mentioned that there had been feedback on suggestions for the Vision, Purpose and Values statements as well as Dr. Baylor and Mr. Walker taking the suggestions and refining them.

Ms. Baylor summarized the process leading to the drafts before the Board.

Mr. Chaquica indicated the Board could take action on one or more elements and table the Values Statement for a future meeting.

President Rawland asked for comments from the Public.

Kathleen Derby, NAMI CA, asked how the values compare to the OAC statement as far as collaborating with clients and family members.

Dr. Baylor clarified that she could find those within the Value Statement under bullet three.

Stephanie Welch, CMHDA, commented regarding the Mission Statement and stated that one way to promote efficiency and effectiveness is to use a statement on “quality.”

The Board agreed that “quality could be added to the Value Statement.”

Bruce Gurganus, MFT, Marin County, questioned the broadness of the Purpose Statement, which had nothing to do with prevention, mental health or health care.

President Rawland stated it was designed as to not limit the JPA and allow for growth by administering other programs.

Vivian Criado, California Elder Mental Health and Aging Coalition, wanted to bring back to the table the purpose is to reflect “prevention and early intervention” which there is no language for in the Purpose Statement. It was added that current language cites mental health which excludes the rest of the population.

Mr. O’Neill wanted to add to Member Gurganus’s comment that the “purpose” maybe adding a preposition at the end of the sentence (example: to deliver...“prevention services, or early intervention”).

Ms. Derby echoed Ms. Welch’s comment in the lack of mention of “quality” as well as “stakeholder process,” within that vision statement.

Mr. Chaquica provided background on the “Purpose Statement” being very precise, global and something an organization may never achieve but always strive for; it defines what you do and why you exist, which is the reason for the generality of the “Purpose Statement.” The “Vision Statement” is something that you aspire to accomplish in 3-5 years.

A motion was made to approve the Vision and Purpose Statements and defer the Values Statement for a future meeting to include comments previously made.

Motion: Wayne Clark, PhD, Monterey County

Second: Maureen Bauman, LCSW, Placer County

The motion carried unanimously.

B. Program Participation Agreement

Mr. Chaquica reminded the Board that the Program Participation Agreement was previously approved but was brought back for clarification on the liability issue by legal counsel.

Mr. Alliston explained that anyone signing a participation agreement is either a member or is someone who is a party to an MOU. This document does not stand by its self, members are held under the JPA Agreement and Bylaws and other provisions that have to do with the sharing of liabilities, and, therefore, not all the provisions will be found in the Participation Agreement. As for the MOU, an indemnification clause has already been added.

William Arroyo asked if someone could explicitly differentiate numbers 7 & 8 of Exhibit A of the Participation Agreement.

Mr. Chaquica stated that this was simply a template as there was no history to rely on and would have staff reword number 7 for less confusion and acknowledged that as we move forward there may be other changes to this document.

President Rawland asked members to provide input on this document encouraging them to obtain additional input from their CFO's.

No motion was made as this was an information item only.

9. PROGRAM MATTERS

A. REPORT FROM CalMHSA Program Director

The Program Director, Edward Walker, brought forward the notes from the Ad Hoc Committee and confirmed Wayne Clark, PhD, Monterey, was appointed chair of the committee and named the other members.

Dr. Clark gave an overview of what was discussed at the Ad Hoc Committee, adding they look to the stakeholders to provide input as they move forward and confirmed a teleconference line would be put in place so stakeholders could partake in these meetings.

After Mr. Walker identified Ms. Ann Marie Rucker as one of the Ad Hoc Committee members, Mary Ann Bennett, Sacramento County, indicated Ann Marie Rucker was her previous alternate (Michelle Callejas being the new alternate) and wondered if it was ok to have Ann Marie Rucker remain on the committee.

The board responded that she volunteered as a Sacramento County representative and therefore was ok.

Ms. Derby appreciated stakeholders being invited to the meetings but mentioned her concern about Brown Act compliance as it relates to posting when a certain number of members get together to discuss business. It was also asked if there had been any further discussions as it relates to regional programs.

President Rawland responded by affirming that Brown Act applies (for purposes of posting) when there are more than a quorum in attendance in a meeting and no further discussions relating to regional programs had taken place; that would probably come in during the planning stages.

Dr. Baylor reiterated all discussion and recommendations that arise from the Ad Hoc Committee will be brought back to the Board for discussion and approval.

Ms. Derby added her desire for a uniform approach so as to not reinvent the process as stakeholders are accustomed to DMH and OAC process and would like to see CalMHSA replicate those.

Lin Benjamin, CA Department of Aging, voiced her concern for ensuring that there is collaboration, state-wideness and proportionality amongst all the programs being implemented.

President Rawland confirmed once projects roll out, those plans will be developed, prepared and presented at the Board meeting then submitted to the OAC for final approval. As such, the OAC would play a part in ensuring state-wideness and proportionality of the funding.

Dr. Clark encouraged stakeholders to join the Ad Hoc Committee to bring their ideas so they get implemented and allow for a comprehensive plan.

Mr. Walker added that the OAC guidelines require those specific concerns be addressed.

President Rawland asked Mr. Walker where we were in terms of stakeholder input on the recommended actions.

Mr. Walker indicated there had been five submissions with great comment but not so much in terms of priorities, which is why the templates were redrafted to clarify priorities are needed to be stated as staff cannot interpret and record otherwise.

Stephanie Welch, California Mental Health Directors Association, expressed it would be helpful for the Office of Suicide Prevention to share with this group what they are working on, if anything, so as not to repeat efforts.

Ms. Criado commented she was concerned with consumers and families not having an opportunity to provide input and would recommend the Board consider the possibility of developing their process for planning away from this body.

Dr. Clark clarified consumer and families had already provided input when the strategic plans were put together and the Board will now put all of that great information into place.

Ms. Derby stated this was a new culture and process confirming CalMHSA's accountability to the public.

Mr. Gruendl agreed to all the comments being made but wanted to point out he does not want us to lose sight of the need for action as suicide rates in his county have been climbing and are an issue.

Michael Kennedy, MFT, Sonoma County, explained they have a lot of planning at the local level and echoed Mr. Gruendl's comments regarding the need for action and hoped some of Sonoma's projects could be replicated.

Ms. Criado reiterated the importance of the community being involved in the decision making process.

President Rawland stated all stakeholder input would be taken into consideration and the Board would take their role seriously and make whatever decisions are necessary. He added that the reversion policy is in place and monies need to be used by 2014, therefore, there is a need to get projects moving.

Mark Refowitz, MSW, Orange County, asked that the agenda be moved forward as a lot of this is general comment.

Ms. Derby reiterated the benefits of including consumers in the process.

B. Technical Assistance and Capacity Building

Sandra Naylor Goodwin, PhD, CiMH, gave a brief report explaining they currently had nine active counties; one dropped out and would have a more in-depth report next month along with contract provisions based on the project involvement.

Dr. Goodwin added they want to get this project off the ground before moving on to the next level.

Ms. Derby asked if this was part of the county planning process, which President Rawland confirmed it was.

Stacie Hiramoto asked to what extent the partners involved are receiving training or implementing some of the training in addition to the county staff who are supposed to be benefiting from that money? How the money is being spent by counties is quite vague.

President Rawland advised CalMHSA has no jurisdiction over how counties are spending Technical Assistance funds other than the nine counties in this particular project.

C. Information Notice 08-37 – Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Funds for Training, Technical Assistance, and Capacity Building Statewide Projects

Mr. Walker brought forward Information Notice 08-37 as it relates to funds for Training and Technical Assistance & Capacity Building projects and whether there is a role for CalMHSA to play in the greater implementation of 08-37.

Dr. Clark stated it was not clear as to how the statewide funds are being distributed and wondered if that was something the JPA would have a role in?

Mr. Walker asked the Board for direction.

Ann Collentine, MHSOAC, mentioned that a draft 2008 report is still undergoing an internal review, which would explain how some counties are using the funds. An informal report is being presented to the commissioners on September 1st, which will then become a public document for all to review. The OAC is also drafting questions for counties to provide feedback on how their allocations are being used.

Ms. Welch re-iterated the importance of reaching out to the MHSA Coordinators and asking them how we can help them utilize those funds.

Ms. Derby asked if there can be a process in which other statewide organizations may assist the JPA in the TA that counties are interested in.

President Rawland explained it would require counties to request to pool their funds for the implementation for those purposes and until there is a request the JPA can't do anything.

Ms. Hiramoto voiced stakeholders supported smaller counties pooling their funds for that purpose but was concerned with the vagueness of how funds are currently being used.

Mr. Refowitz asked the agenda be moved forward as these were all general comments.

The board agreed.

10. NEW BUSINESS

Mr. O'Neill indicated at the last meeting they entertained the idea that we might consider health care integration in future projects and believed CiMH was going to draft a report on the topic.

Dr. Goodwin and Dr. Clark clarified due to the 11-15 Waiver there had been a tsunami of issues and as a result of, the Board decided to hold off on this for a while.

Ms. Bennett asked for clarification on the reversion policy to which President Rawland indicated the clock was re-set and funds now need to be expensed by June 30, 2014.

11. CalMHSA – GENERAL DISCUSSION

Mr. Chaquica briefly mentioned CalMHSA had a procurement policy and it is very general, if it needed to be expanded now would be the time and asked any examples be sent to him. He added a draft of the procurement policy would be brought to the board at the September meeting.

Mr. Chaquica reminded members a revision of the bylaws was sent to everyone in form of a 30-day notice due to the voting mechanism being left out to which it will now be included. This item will be brought back to the Board for ratification at the September meeting.

12. CLOSING COMMENTS

Dr. Clark mentioned the various themes were discussed such as urgency, process and inclusion and asked everyone work together on getting some of these projects off the ground in the next six months.

13. ADJOURNMENT

No additional public comment was made.

A motion was made to adjourn.

President Allan Rawland adjourned the meeting at 4:45 pm.

Respectfully submitted,

Ms. Maureen Bauman, LCSW

Secretary, CalMHSA

Date

Current Membership Roster

- 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)
- (19 members 20 counties)

CalMHSA's Regional Representatives

Superior Area – Scott Gruendl, MPA, Glenn County

Central Area – Denise Hunt, MFT, Stanislaus County

Bay Area – Michael Kennedy, MFT, Sonoma County

Southern Area – Mark Refowitz, MSW, Orange County

Los Angeles Area – William Arroyo, MD, Los Angeles County

LIST A

(Chance of becoming a member, have indicated interest and moving forward)

Contra Costa, El Dorado, Fresno, Humboldt, Imperial, Kern, Kings, Mendocino, Napa, Riverside, San Diego (MOU Participation), Santa Clara, Siskiyou, Ventura

LIST B

(Have expressed interest but not sure what to do, internal discussions necessary)

City of Berkeley, Calaveras, Madera, Merced, San Mateo

LIST C

(Don't know, have many questions)

Alameda, Alpine, Amador, Del Norte, Lake, Lassen, Mariposa, Nevada, San Benito, San Francisco, San Joaquin, Santa Barbara, Shasta, Tehama, Tri-City, Tulare, Tuolumne

LIST D

(Have opted out)

Inyo, Mono, Plumas

MEMBER COUNTIES

Butte, Colusa, Glenn, Los Angeles, Modoc , Monterey, Placer, Sacramento, San Bernardino, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Yuba, Trinity, Orange, Marin, Yolo



STATE OF CALIFORNIA

WARRANT NUMBER

06-078864

THE TREASURER OF THE STATE WILL PAY OUT OF THE

FUND NO. FUND NAME
3085 MENTAL HEALTH SERVICES

IDENTIFICATION NO.

MO. DAY YR.
4450 08 05 2010

90-1342/1211

06078864

TO: 078864
--- CAL-MHSA

VOID

DOLLARS	CENTS
\$***94710	00

John Chiang
JOHN CHIANG
 CALIFORNIA STATE CONTROLLER



⑆121113423⑆ 060788646⑆

FORM 04-08 (2-97) CONTROLLERS WARRANT



STATE OF CALIFORNIA

WARRANT NUMBER

06-078865

H THE TREASURER OF THE STATE WILL PAY OUT OF THE

FUND NO. FUND NAME
3085 MENTAL HEALTH SERVICES

IDENTIFICATION NO.

MO. DAY YR.
4450 08 05 2010

90-1342/1211

06078865

TO: 078865
--- CAL-MHSA

VOID

DOLLARS	CENTS
\$***74655	00

John Chiang
JOHN CHIANG
 CALIFORNIA STATE CONTROLLER



⑆121113423⑆ 060788655⑆

FORM 04-08 (2-97) CONTROLLERS WARRANT



STATE OF CALIFORNIA

WARRANT NUMBER

09-121855

THE TREASURER OF THE STATE WILL PAY OUT OF THE

FUND NO. FUND NAME
3085 MENTAL HEALTH SERVICES FUND

90-1342/1211

TO: CAL MHSA

VOID

ISSUE DATE	DOLLARS	CENTS
MO. DAY YR. 08 06 2010	\$ *****74655	00

John Chiang
JOHN CHIANG
 CALIFORNIA STATE CONTROLLER



⑆121113423⑆ 09121855⑆

FORM 09-08 (7/01) CONTROLLERS WARRANT

CalMHSA Membership and PEI Assignment Status

MENTAL HEALTH DIRECTOR LISTING							30-DAY POSTING		Assigned Funds to DMH	Assigned Funds to CalMHSA	TOTAL FUNDS (planning & program)
Member/Prospect	Contact Name	Telephone	Interest	BOS Approval	CalMHSA Board Approval	JPA Signature	End Date			BALANCE	
Alameda	Marye L. Thomas, MD	(510) 567-8120	Unknown	No	No	No		No		\$5,830,000.00	\$5,830,000.00
Alpine	Pamela Knorr	(530) 694-2287	Unknown	No	No	No		No		\$100,000.00	\$100,000.00
Amador	George E Sonsel, LCSW	(209) 223-6296	Unknown	No	No	No		1/13/09		\$126,400.00	\$126,400.00
Berkeley City	Jo Ruffin	(510) 981-5213	Yes	No	No	No		No		\$511,600.00	\$511,600.00
Butte	Anne Robin, MFT	(530) 891-3044	Member	Yes	Yes	Yes	7/11/10	Yes	8/4/2010	\$842,380.00	\$875,200.00
Calaveras	Rita Downs, MPA	(209) 754-6555	Yes	No	No	No		No		\$165,200.00	\$165,200.00
Colusa	Edmund Smith	(530) 458-0822	Member	Yes	Yes	Yes		No		\$100,000.00	\$100,000.00
Contra Costa	Donna Wilgand, LCSW	(925) 957-5111	Yes	No	No	No		No		\$3,668,800.00	\$3,668,800.00
Del Norte	Gary Blatnick	(707) 464-7224	Unknown	No	No	No		No		\$101,200.00	\$101,200.00
El Dorado	Christine Kondo-Lister, LCSW	(530) 621-6270	Yes	No	No	No		No		\$580,800.00	\$580,800.00
Fresno	Donna Taylor, RN	(559) 253-9183	Unknown	No	No	No		No		\$3,994,000.00	\$3,994,000.00
Glenn	Scott Gruendl, MPA	(530) 934-6582	Member	Yes	Yes	Yes	5/31/10	12/26/08		\$108,400.00	\$108,400.00
Humboldt	Karolyn Rim Stein, RN	(707) 268-2990	Yes	No	No	No		12/12/08		\$502,800.00	\$502,800.00
Imperial	Michael Horn, MFT	(760) 482-4068	Unknown	No	No	No		No		\$750,000.00	\$750,000.00
Inyo	Gail Zwier, PhD	(760) 873-6533	No	No	No	No		No		\$100,000.00	\$100,000.00
Kern	Jim Waterman, PhD	(661) 686-6009	Yes	No	No	No		No		\$3,423,600.00	\$3,423,600.00
Kings	Mary Anne Ford Sherman	(559) 582-3211	Unknown	No	No	No		No		\$600,000.00	\$600,000.00
Lake	Kristy Kelly, MFT	(707) 263-4338	Unknown	No	No	No		2/4/09		\$236,800.00	\$236,800.00
Lassen	Ken Crandall, ASW	(530) 251-8108	Yes	No	No	No		No		\$101,200.00	\$101,200.00
Los Angeles	Marvin J Southard, DSW	(213) 738-4601	Yes	Yes	Yes	Yes		No		\$46,713,600.00	\$46,713,600.00
Madera	Janice Melton, LCSW	(559) 675-7926	Yes	No	No	No		No		\$649,600.00	\$649,600.00
Marin	Bruce Gurganus, MFT	(415) 499-6769	Yes	7/20/10	8/12/10	Yes	5/31/10	12/9/08		\$889,600.00	\$889,600.00
Mariposa	James A Rydingsword	(209) 966-2000	Unknown	No	No	No		No		\$100,000.00	\$100,000.00
Mendocino	Mary Elliott	(707) 463-5481	Yes	No	No	No		3/11/09		\$328,000.00	\$328,000.00
Merced	Manuel J. Jimenez, MFT	(209) 381-6805	Yes	No	No	No		12/22/08		\$1,132,800.00	\$1,132,800.00
Modoc	Karen Stockton, PhD, MSW	(530) 233-6312	Member	Yes	Yes	Yes	5/31/10	1/9/09		\$100,000.00	\$100,000.00
Mono	Ann Gimpel, PhD, MSW	(760) 924-1740	No	No	No	No		No		\$100,000.00	\$100,000.00
Monterey	Wayne W. Clark, PhD	(831) 755-4509	Member	Yes	Yes	Yes	5/31/10	5/11/10	8/4/2010	\$1,757,910.00	\$1,826,400.00
Napa	Jaye Vanderhurst	(707) 453-4279	Yes	No	No	No		No		\$484,400.00	\$484,400.00
Nevada	Michael Heggarty, MFT	(530) 265-1437	Unknown	No	No	No		Opt Out		\$346,000.00	\$346,000.00
Orange	Mark A. Refowitz	(714) 834-6023	Yes	7/20/10	8/12/10	7/23/10		1/6/09	8/24/2010	\$12,836,670.00	\$13,336,800.00
Placer	Maureen Bauman, LCSW	(530) 889-7256	Member	Yes	Yes	Yes		No		\$1,096,400.00	\$1,096,400.00
Plumas	John Sebold, LCSW	(530) 283-6307	No	No	No	No		No		\$100,000.00	\$100,000.00
Riverside	Jerry A. Wengerd, LCSW	(951) 358-4501	Yes	No	No	No		No		\$8,856,000.00	\$8,856,000.00
Sacramento	Mary Ann Bennett	(916) 875-9904	Member	Yes	Yes	Yes		No		\$5,327,200.00	\$5,327,200.00
San Benito	Alan Yamamoto, LCSW	(831) 636-4020	Unknown	No	No	No		No		\$221,600.00	\$221,600.00
San Bernardino	Allan Rawland, ACSW, MSW	(909) 382-3133	Member	Yes	Yes	Yes		No	8/24/2010	\$8,292,130.00	\$8,615,200.00
San Diego	Alfredo Aguirre, LCSW	(619) 563-2765	Yes	No	No	No		12/17/08		\$13,506,800.00	\$13,506,800.00
San Francisco	Jo Robbins, MFT	(415) 255-3447	Yes	No	No	No		No		\$3,020,400.00	\$3,020,400.00
San Joaquin	Victor Singh, LCSW	(209) 468-8750	Unknown	No	No	No		Opt Out		\$2,678,000.00	\$2,678,000.00
San Luis Obispo	Karen Baylor, PhD	(805) 781-4734	Member	Yes	Yes	Yes		No	8/24/2010	\$993,300.00	\$1,032,000.00
San Mateo	Louise Rogers, MPA	(650) 573-2532	Yes	No	No	No		No		\$2,610,800.00	\$2,610,800.00
Santa Barbara	Ann Detrick, PhD	(805) 681-5233	Unknown	No	No	No		12/9/08		\$1,808,800.00	\$1,808,800.00

CalMHSA Membership and PEI Assignment Status

MENTAL HEALTH DIRECTOR LISTING							30-DAY POSTING		Assigned Funds to DMH	Assigned Funds to CalMHSA	BALANCE	TOTAL FUNDS (planning & program)
Member/Prospect	Contact Name	Telephone	Interest	BOS Approval	CalMHSA Board Approval	JPA Signature	End Date					
Santa Clara	Nancy Pena, PhD	(408) 885-5782	Yes	8/10/2010	Pending	Pending		12/16/08		\$7,707,600.00	\$7,707,600.00	
Santa Cruz	Leslie Tremaine, Ed.D.	(831) 454-4515	Yes	Yes	Yes	Yes		1/5/09	8/4/2010	\$1,087,625.00	\$1,130,000.00	
Shasta	Mark Montgomery, Psy.D.	(530) 225-5900	No	No	No	No		Opt Out		\$704,400.00	\$704,400.00	
Sierra	Carol Roberts, PhD	(530) 993-6700	Unknown	No	No	No		No		\$100,000.00	\$100,000.00	
Siskiyou	Lauri A. Hunner, LCSW	(530) 841-4801	Yes	No	No	No		No		\$143,200.00	\$143,200.00	
Solano	Glenda Lingenfelter, RN	(707) 784-8320	Member	Yes	Yes	Yes		1/27/09	8/4/2010	\$1,584,345.00	\$1,604,400.00	
Sonoma	Michael Kennedy, MFT	(707) 565-5157	Member	Yes	Yes	Yes	5/31/10	No		\$1,758,800.00	\$1,758,800.00	
Stanislaus	Denise C. Hunt, RN, MFT	(209) 525-6225	Member	Yes	Yes	Yes		12/11/08	8/4/2010	\$1,964,270.00	\$2,040,800.00	
Sutter/Yuba	Brad Luz, PhD	(530) 822-7200	Member	Yes	Yes	Yes		6/18/09		\$600,800.00	\$600,800.00	
Tehama	Ann Houghtby, MFT	(530) 527-8491	Unknown	No	No	No		No		\$242,800.00	\$242,800.00	
Tri-City	Jesse H. Duff	(909) 623-6131	Unknown	No	No	No		No		\$817,200.00	\$817,200.00	
Trinity	Noel O'Neill, LMFT	(530) 623-1362	Member	Yes	Yes	Yes		No	8/4/2010	\$96,250.00	\$100,000.00	
Tulare	Cheryl L. Duerksen, PhD	(559) 737-4660	Unknown	No	No	No		No		\$1,928,400.00	\$1,928,400.00	
Tuolumne	Tracy Riggs	(209) 533-6245	Unknown	No	No	No		No		\$193,200.00	\$193,200.00	
Ventura	Meloney Roy, LCSW	(805) 981-2214	Yes	No	No	No		No		\$3,339,200.00	\$3,339,200.00	
Yolo	Kim Suderman	(530) 666-8516	Yes	7/27/10	8/12/10	Pending	6/14/10	4/24/09		\$832,800.00	\$832,800.00	
Legend									\$1,105,920.00	\$158,894,080.00	\$160,000,000.00	
Member Counties							Updated as of August 30, 2010					

		PEI State Administered Projects Fund Assignment Options							Distributions			
County/Total Available Funds	FY	PEI Statewide Programs Component Allocation per FY	Option 1 Delegated to JPA ¹	Option 2 Multi County Collaborative ²	Option 3 Assignment ³		Balance / Not Assigned	Date Assignment Request Received by DMH	Planning		Services	
					State	JPA			Amount	Date Released	Amount	Date Released
Alameda \$5,830,000	FY 08/09	\$1,457,500	\$0	\$0	\$0	\$0	\$1,457,500		\$0			
	FY 09/10	\$1,457,500	\$0	\$0	\$0	\$0	\$1,457,500		\$0			
	FY 10/11	\$1,457,500	\$0	\$0	\$0	\$0	\$1,457,500		\$0			
	FY 11/12	\$1,457,500	\$0	\$0	\$0	\$0	\$1,457,500		\$0			
Alpine \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Amador \$126,400	FY 08/09	\$31,600	\$0	\$0	\$31,600	\$0	\$0	1/13/2009	\$0			
	FY 09/10	\$31,600	\$0	\$0	\$31,600	\$0	\$0	1/13/2009	\$0			
	FY 10/11	\$31,600	\$0	\$0	\$31,600	\$0	\$0	1/13/2009	\$0			
	FY 11/12	\$31,600	\$0	\$0	\$31,600	\$0	\$0	1/13/2009	\$0			
Berkeley City \$511,600	FY 08/09	\$127,900	\$0	\$0	\$0	\$0	\$127,900		\$0			
	FY 09/10	\$127,900	\$0	\$0	\$0	\$0	\$127,900		\$0			
	FY 10/11	\$127,900	\$0	\$0	\$0	\$0	\$127,900		\$0			
	FY 11/12	\$127,900	\$0	\$0	\$0	\$0	\$127,900		\$0			
Butte \$875,200	FY 08/09	\$218,800	\$0	\$0	\$0	\$218,800	\$0	6/21/2010	\$10,940	8/4/2010		
	FY 09/10	\$218,800	\$0	\$0	\$0	\$218,800	\$0	6/21/2010	\$10,940	8/4/2010		
	FY 10/11	\$218,800	\$0	\$0	\$0	\$218,800	\$0	6/21/2010	\$10,940	8/4/2010		
	FY 11/12	\$218,800	\$0	\$0	\$0	\$218,800	\$0	6/21/2010	\$0			
Calaveras \$165,200	FY 08/09	\$41,300	\$0	\$0	\$0	\$0	\$41,300		\$0			
	FY 09/10	\$41,300	\$0	\$0	\$0	\$0	\$41,300		\$0			
	FY 10/11	\$41,300	\$0	\$0	\$0	\$0	\$41,300		\$0			
	FY 11/12	\$41,300	\$0	\$0	\$0	\$0	\$41,300		\$0			
Colusa \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Contra Costa \$3,668,800	FY 08/09	\$917,200	\$0	\$0	\$0	\$0	\$917,200		\$0			
	FY 09/10	\$917,200	\$0	\$0	\$0	\$0	\$917,200		\$0			
	FY 10/11	\$917,200	\$0	\$0	\$0	\$0	\$917,200		\$0			
	FY 11/12	\$917,200	\$0	\$0	\$0	\$0	\$917,200		\$0			
Del Norte \$101,200	FY 08/09	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
	FY 09/10	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
	FY 10/11	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
	FY 11/12	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
El Dorado \$580,800	FY 08/09	\$145,200	\$0	\$0	\$0	\$0	\$145,200		\$0			
	FY 09/10	\$145,200	\$0	\$0	\$0	\$0	\$145,200		\$0			
	FY 10/11	\$145,200	\$0	\$0	\$0	\$0	\$145,200		\$0			
	FY 11/12	\$145,200	\$0	\$0	\$0	\$0	\$145,200		\$0			
	FY 08/09	\$998,500	\$0	\$0	\$0	\$0	\$998,500		\$0			

County/Total Available Funds	FY	PEI Statewide Programs Component Allocation per FY	PEI State Administered Projects Fund Assignment Options						Distributions			
			Option 1 Delegated to JPA ¹	Option 2 Multi County Collaborative ²	Option 3 Assignment ³		Balance / Not Assigned	Date Assignment Request Received by DMH	Planning		Services	
					State	JPA			Amount	Date Released	Amount	Date Released
Fresno \$3,994,000	FY 09/10	\$998,500	\$0	\$0	\$0	\$0	\$998,500		\$0			
	FY 10/11	\$998,500	\$0	\$0	\$0	\$0	\$998,500		\$0			
	FY 11/12	\$998,500	\$0	\$0	\$0	\$0	\$998,500		\$0			
Glenn \$108,400	FY 08/09	\$27,100	\$0	\$0	\$27,100	\$0	\$0	12/26/2008	\$0			
	FY 09/10	\$27,100	\$0	\$0	\$27,100	\$0	\$0	12/26/2008	\$0			
	FY 10/11	\$27,100	\$0	\$0	\$27,100	\$0	\$0	12/26/2008	\$0			
	FY 11/12	\$27,100	\$0	\$0	\$27,100	\$0	\$0	12/26/2008	\$0			
Humboldt \$502,800	FY 08/09	\$125,700	\$0	\$0	\$125,700	\$0	\$0	12/12/2008	\$0			
	FY 09/10	\$125,700	\$0	\$0	\$0	\$0	\$125,700		\$0			
	FY 10/11	\$125,700	\$0	\$0	\$0	\$0	\$125,700		\$0			
	FY 11/12	\$125,700	\$0	\$0	\$0	\$0	\$125,700		\$0			
Imperial \$750,000	FY 08/09	\$187,500	\$0	\$0	\$0	\$0	\$187,500		\$0			
	FY 09/10	\$187,500	\$0	\$0	\$0	\$0	\$187,500		\$0			
	FY 10/11	\$187,500	\$0	\$0	\$0	\$0	\$187,500		\$0			
	FY 11/12	\$187,500	\$0	\$0	\$0	\$0	\$187,500		\$0			
Inyo \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Kern \$3,423,600	FY 08/09	\$855,900	\$0	\$0	\$0	\$0	\$855,900		\$0			
	FY 09/10	\$855,900	\$0	\$0	\$0	\$0	\$855,900		\$0			
	FY 10/11	\$855,900	\$0	\$0	\$0	\$0	\$855,900		\$0			
	FY 11/12	\$855,900	\$0	\$0	\$0	\$0	\$855,900		\$0			
Kings \$600,000	FY 08/09	\$150,000	\$0	\$0	\$0	\$0	\$150,000		\$0			
	FY 09/10	\$150,000	\$0	\$0	\$0	\$0	\$150,000		\$0			
	FY 10/11	\$150,000	\$0	\$0	\$0	\$0	\$150,000		\$0			
	FY 11/12	\$150,000	\$0	\$0	\$0	\$0	\$150,000		\$0			
Lake \$236,800	FY 08/09	\$59,200	\$0	\$0	\$59,200	\$0	\$0	2/4/2009	\$0			
	FY 09/10	\$59,200	\$0	\$0	\$0	\$0	\$59,200		\$0			
	FY 10/11	\$59,200	\$0	\$0	\$0	\$0	\$59,200		\$0			
	FY 11/12	\$59,200	\$0	\$0	\$0	\$0	\$59,200		\$0			
Lassen \$101,200	FY 08/09	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
	FY 09/10	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
	FY 10/11	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
	FY 11/12	\$25,300	\$0	\$0	\$0	\$0	\$25,300		\$0			
Los Angeles \$46,713,600	FY 08/09	\$11,678,400	\$0	\$0	\$0	\$0	\$11,678,400		\$0			
	FY 09/10	\$11,678,400	\$0	\$0	\$0	\$0	\$11,678,400		\$0			
	FY 10/11	\$11,678,400	\$0	\$0	\$0	\$0	\$11,678,400		\$0			
	FY 11/12	\$11,678,400	\$0	\$0	\$0	\$0	\$11,678,400		\$0			
Madera	FY 08/09	\$162,400	\$0	\$0	\$0	\$0	\$162,400		\$0			
	FY 09/10	\$162,400	\$0	\$0	\$0	\$0	\$162,400		\$0			

		PEI State Administered Projects Fund Assignment Options							Distributions			
County/Total Available Funds	FY	PEI Statewide Programs Component Allocation per FY	Option 1 Delegated to JPA ¹	Option 2 Multi County Collaborative ²	Option 3 Assignment ³		Balance / Not Assigned	Date Assignment Request Received by DMH	Planning		Services	
					State	JPA			Amount	Date Released	Amount	Date Released
\$649,600	FY 10/11	\$162,400	\$0	\$0	\$0	\$0	\$162,400		\$0			
	FY 11/12	\$162,400	\$0	\$0	\$0	\$0	\$162,400		\$0			
Marin \$889,600	FY 08/09	\$222,400	\$0	\$0	\$0	\$222,400	\$0	8/2/2010	\$11,120			
	FY 09/10	\$222,400	\$0	\$0	\$0	\$222,400	\$0	8/2/2010	\$11,120			
	FY 10/11	\$222,400	\$0	\$0	\$0	\$222,400	\$0	8/2/2010	\$11,120			
	FY 11/12	\$222,400	\$0	\$0	\$0	\$222,400	\$0	8/2/2010	\$0			
Mariposa \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Mendocino \$328,000	FY 08/09	\$82,000	\$0	\$0	\$82,000	\$0	\$0	3/11/2009	\$0			
	FY 09/10	\$82,000	\$0	\$0	\$82,000	\$0	\$0	3/11/2009	\$0			
	FY 10/11	\$82,000	\$0	\$0	\$82,000	\$0	\$0	3/11/2009	\$0			
	FY 11/12	\$82,000	\$0	\$0	\$82,000	\$0	\$0	3/11/2009	\$0			
Merced \$1,132,800	FY 08/09	\$283,200	\$0	\$0	\$283,200	\$0	\$0	12/22/2008	\$0			
	FY 09/10	\$283,200	\$0	\$0	\$283,200	\$0	\$0	12/22/2008	\$0			
	FY 10/11	\$283,200	\$0	\$0	\$283,200	\$0	\$0	12/22/2008	\$0			
	FY 11/12	\$283,200	\$0	\$0	\$283,200	\$0	\$0	12/22/2008	\$0			
Modoc \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$25,000	\$0	7/26/2010	\$1,250			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$25,000	\$0	7/26/2010	\$1,250			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$25,000	\$0	7/26/2010	\$1,250			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$25,000	\$0	7/26/2010	\$0			
Mono \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Monterey \$1,826,400	FY 08/09	\$456,600	\$0	\$0	\$0	\$456,600	\$0	5/11/2010	\$22,830	8/4/2010		
	FY 09/10	\$456,600	\$0	\$0	\$0	\$456,600	\$0	5/11/2010	\$22,830	8/4/2010		
	FY 10/11	\$456,600	\$0	\$0	\$0	\$456,600	\$0	5/11/2010	\$22,830	8/4/2010		
	FY 11/12	\$456,600	\$0	\$0	\$0	\$456,600	\$0	5/11/2010	\$0			
Napa \$484,400	FY 08/09	\$121,100	\$0	\$0	\$0	\$0	\$121,100		\$0			
	FY 09/10	\$121,100	\$0	\$0	\$0	\$0	\$121,100		\$0			
	FY 10/11	\$121,100	\$0	\$0	\$0	\$0	\$121,100		\$0			
	FY 11/12	\$121,100	\$0	\$0	\$0	\$0	\$121,100		\$0			
Nevada ⁴ \$346,000	FY 08/09	\$86,500	\$0	\$0	\$0	\$0	\$0	9/3/2009	\$0			
	FY 09/10	\$86,500	\$0	\$0	\$0	\$0	\$0	9/3/2009	\$0			
	FY 10/11	\$86,500	\$0	\$0	\$0	\$0	\$0	6/24/2010	\$0			
	FY 11/12	\$86,500	\$0	\$0	\$0	\$0	\$86,500		\$0			
Orange \$13,336,800	FY 08/09	\$3,334,200	\$0	\$0	\$0	\$3,334,200	\$0	8/2/2010	\$166,710			
	FY 09/10	\$3,334,200	\$0	\$0	\$0	\$3,334,200	\$0	8/2/2010	\$166,710			
	FY 10/11	\$3,334,200	\$0	\$0	\$0	\$3,334,200	\$0	8/2/2010	\$166,710			

		PEI State Administered Projects Fund Assignment Options							Distributions			
County/Total Available Funds	FY	PEI Statewide Programs Component Allocation per FY	Option 1 Delegated to JPA ¹	Option 2 Multi County Collaborative ²	Option 3 Assignment ³		Balance / Not Assigned	Date Assignment Request Received by DMH	Planning		Services	
					State	JPA			Amount	Date Released	Amount	Date Released
	FY 11/12	\$3,334,200	\$0	\$0	\$0	\$3,334,200	\$0	8/2/2010	\$0			
Placer \$1,096,400	FY 08/09	\$274,100	\$0	\$0	\$0	\$274,100	\$0	7/26/2010	\$13,705			
	FY 09/10	\$274,100	\$0	\$0	\$0	\$274,100	\$0	7/26/2010	\$13,705			
	FY 10/11	\$274,100	\$0	\$0	\$0	\$274,100	\$0	7/26/2010	\$13,705			
	FY 11/12	\$274,100	\$0	\$0	\$0	\$274,100	\$0	7/26/2010	\$0			
Plumas \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Riverside \$8,856,000	FY 08/09	\$2,214,000	\$0	\$0	\$0	\$0	\$2,214,000		\$0			
	FY 09/10	\$2,214,000	\$0	\$0	\$0	\$0	\$2,214,000		\$0			
	FY 10/11	\$2,214,000	\$0	\$0	\$0	\$0	\$2,214,000		\$0			
	FY 11/12	\$2,214,000	\$0	\$0	\$0	\$0	\$2,214,000		\$0			
Sacramento \$5,327,200	FY 08/09	\$1,331,800	\$0	\$0	\$0	\$0	\$1,331,800		\$0			
	FY 09/10	\$1,331,800	\$0	\$0	\$0	\$0	\$1,331,800		\$0			
	FY 10/11	\$1,331,800	\$0	\$0	\$0	\$0	\$1,331,800		\$0			
	FY 11/12	\$1,331,800	\$0	\$0	\$0	\$0	\$1,331,800		\$0			
San Benito \$221,600	FY 08/09	\$55,400	\$0	\$0	\$0	\$0	\$55,400		\$0			
	FY 09/10	\$55,400	\$0	\$0	\$0	\$0	\$55,400		\$0			
	FY 10/11	\$55,400	\$0	\$0	\$0	\$0	\$55,400		\$0			
	FY 11/12	\$55,400	\$0	\$0	\$0	\$0	\$55,400		\$0			
San Bernardino \$8,615,200	FY 08/09	\$2,153,800	\$0	\$0	\$0	\$2,153,800	\$0	8/10/2010	\$107,690			
	FY 09/10	\$2,153,800	\$0	\$0	\$0	\$2,153,800	\$0	8/10/2010	\$107,690			
	FY 10/11	\$2,153,800	\$0	\$0	\$0	\$2,153,800	\$0	8/10/2010	\$107,690			
	FY 11/12	\$2,153,800	\$0	\$0	\$0	\$2,153,800	\$0	8/10/2010	\$0			
San Diego \$13,506,800	FY 08/09	\$3,376,700	\$0	\$0	\$0	\$3,376,700	\$0	7/27/2010	\$168,835	8/16/2010		
	FY 09/10	\$3,376,700	\$0	\$0	\$0	\$3,376,700	\$0	7/27/2010	\$168,835	8/16/2010		
	FY 10/11	\$3,376,700	\$0	\$0	\$0	\$3,376,700	\$0	7/27/2010	\$168,835	8/17/2010		
	FY 11/12	\$3,376,700	\$0	\$0	\$0	\$3,376,700	\$0	7/27/2010	\$0			
San Francisco \$3,020,400	FY 08/09	\$755,100	\$0	\$0	\$0	\$0	\$755,100		\$0			
	FY 09/10	\$755,100	\$0	\$0	\$0	\$0	\$755,100		\$0			
	FY 10/11	\$755,100	\$0	\$0	\$0	\$0	\$755,100		\$0			
	FY 11/12	\$755,100	\$0	\$0	\$0	\$0	\$755,100		\$0			
San Joaquin ⁴ \$2,678,000	FY 08/09	\$669,500	\$0	\$0	\$0	\$0	\$0	9/3/2009	\$0			
	FY 09/10	\$669,500	\$0	\$0	\$0	\$0	\$0	9/3/2009	\$0			
	FY 10/11	\$669,500	\$0	\$0	\$0	\$0	\$0	5/13/2010	\$0			
	FY 11/12	\$669,500	\$0	\$0	\$0	\$0	\$669,500		\$0			
San Luis Obispo \$1,032,000	FY 08/09	\$258,000	\$258,000	\$0	\$0	\$0	\$0	7/26/2010	\$12,900			
	FY 09/10	\$258,000	\$258,000	\$0	\$0	\$0	\$0	7/26/2010	\$12,900			
	FY 10/11	\$258,000	\$258,000	\$0	\$0	\$0	\$0	7/26/2010	\$12,900			
	FY 11/12	\$258,000	\$258,000	\$0	\$0	\$0	\$0	7/26/2010	\$0			

		PEI State Administered Projects Fund Assignment Options							Distributions			
County/Total Available Funds	FY	PEI Statewide Programs Component Allocation per FY	Option 1 Delegated to JPA ¹	Option 2 Multi County Collaborative ²	Option 3 Assignment ³		Balance / Not Assigned	Date Assignment Request Received by DMH	Planning		Services	
					State	JPA			Amount	Date Released	Amount	Date Released
San Mateo \$2,610,800	FY 08/09	\$652,700	\$0	\$0	\$0	\$0	\$652,700		\$0			
	FY 09/10	\$652,700	\$0	\$0	\$0	\$0	\$652,700		\$0			
	FY 10/11	\$652,700	\$0	\$0	\$0	\$0	\$652,700		\$0			
	FY 11/12	\$652,700	\$0	\$0	\$0	\$0	\$652,700		\$0			
Santa Barbara \$1,808,800	FY 08/09	\$452,200	\$0	\$0	\$452,200	\$0	\$0	12/9/2008	\$0			
	FY 09/10	\$452,200	\$0	\$0	\$452,200	\$0	\$0	12/9/2008	\$0			
	FY 10/11	\$452,200	\$0	\$0	\$452,200	\$0	\$0	12/9/2008	\$0			
	FY 11/12	\$452,200	\$0	\$0	\$452,200	\$0	\$0	12/9/2008	\$0			
Santa Clara \$7,707,600	FY 08/09	\$1,926,900	\$0	\$0	\$1,926,900	\$0	\$0	12/16/2008	\$0			
	FY 09/10	\$1,926,900	\$0	\$0	\$1,926,900	\$0	\$0	12/16/2008	\$0			
	FY 10/11	\$1,926,900	\$0	\$0	\$1,926,900	\$0	\$0	12/16/2008	\$0			
	FY 11/12	\$1,926,900	\$0	\$0	\$1,926,900	\$0	\$0	12/16/2008	\$0			
Santa Cruz \$1,130,000	FY 08/09	\$282,500	\$0	\$0	\$0	\$282,500	\$0	6/24/2010	\$14,125	8/4/2010		
	FY 09/10	\$282,500	\$0	\$0	\$0	\$282,500	\$0	6/24/2010	\$14,125	8/4/2010		
	FY 10/11	\$282,500	\$0	\$0	\$0	\$282,500	\$0	6/24/2010	\$14,125	8/4/2010		
	FY 11/12	\$282,500	\$0	\$0	\$0	\$282,500	\$0	6/24/2010	\$0			
Shasta ⁴ \$704,400	FY 08/09	\$176,100	\$0	\$0	\$0	\$0	\$0	9/3/2009	\$0			
	FY 09/10	\$176,100	\$0	\$0	\$0	\$0	\$0	9/3/2009	\$0			
	FY 10/11	\$176,100	\$0	\$0	\$0	\$0	\$0	5/6/2010	\$0			
	FY 11/12	\$176,100	\$0	\$0	\$0	\$0	\$176,100		\$0			
Sierra \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 09/10	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 10/11	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
	FY 11/12	\$25,000	\$0	\$0	\$0	\$0	\$25,000		\$0			
Siskiyou \$143,200	FY 08/09	\$35,800	\$0	\$0	\$0	\$0	\$35,800		\$0			
	FY 09/10	\$35,800	\$0	\$0	\$0	\$0	\$35,800		\$0			
	FY 10/11	\$35,800	\$0	\$0	\$0	\$0	\$35,800		\$0			
	FY 11/12	\$35,800	\$0	\$0	\$0	\$0	\$35,800		\$0			
Solano \$1,604,400	FY 08/09	\$401,100	\$0	\$0	\$0	\$401,100	\$0	7/1/2010	\$20,055	8/4/2010		
	FY 09/10	\$401,100	\$0	\$0	\$0	\$0	\$401,100		\$0			
	FY 10/11	\$401,100	\$0	\$0	\$0	\$0	\$401,100		\$0			
	FY 11/12	\$401,100	\$0	\$0	\$0	\$0	\$401,100		\$0			
Sonoma \$1,758,800	FY 08/09	\$439,700	\$0	\$0	\$0	\$0	\$439,700		\$0			
	FY 09/10	\$439,700	\$0	\$0	\$0	\$0	\$439,700		\$0			
	FY 10/11	\$439,700	\$0	\$0	\$0	\$0	\$439,700		\$0			
	FY 11/12	\$439,700	\$0	\$0	\$0	\$0	\$439,700		\$0			
Stanislaus \$2,040,800	FY 08/09	\$510,200	\$0	\$0	\$0	\$510,200	\$0	6/15/2010	\$25,510	8/4/2010		
	FY 09/10	\$510,200	\$0	\$0	\$0	\$510,200	\$0	6/15/2010	\$25,510	8/4/2010		
	FY 10/11	\$510,200	\$0	\$0	\$0	\$510,200	\$0	6/15/2010	\$25,510	8/4/2010		
	FY 11/12	\$510,200	\$0	\$0	\$0	\$510,200	\$0	6/15/2010	\$0			
	FY 08/09	\$150,200	\$0	\$0	\$150,200	\$0	\$0	6/18/2009	\$0			

County/Total Available Funds	FY	PEI Statewide Programs Component Allocation per FY	PEI State Administered Projects Fund Assignment Options						Distributions			
			Option 1 Delegated to JPA ¹	Option 2 Multi County Collaborative ²	Option 3 Assignment ³		Balance / Not Assigned	Date Assignment Request Received by DMH	Planning		Services	
					State	JPA			Amount	Date Released	Amount	Date Released
Sutter-Yuba \$600,800	FY 09/10	\$150,200	\$0	\$0	\$0	\$0	\$150,200		\$0			
	FY 10/11	\$150,200	\$0	\$0	\$0	\$0	\$150,200		\$0			
	FY 11/12	\$150,200	\$0	\$0	\$0	\$0	\$150,200		\$0			
Tehama \$242,800	FY 08/09	\$60,700	\$0	\$0	\$0	\$0	\$60,700		\$0			
	FY 09/10	\$60,700	\$0	\$0	\$0	\$0	\$60,700		\$0			
	FY 10/11	\$60,700	\$0	\$0	\$0	\$0	\$60,700		\$0			
	FY 11/12	\$60,700	\$0	\$0	\$0	\$0	\$60,700		\$0			
Tri-City \$817,200	FY 08/09	\$204,300	\$0	\$0	\$0	\$0	\$204,300		\$0			
	FY 09/10	\$204,300	\$0	\$0	\$0	\$0	\$204,300		\$0			
	FY 10/11	\$204,300	\$0	\$0	\$0	\$0	\$204,300		\$0			
	FY 11/12	\$204,300	\$0	\$0	\$0	\$0	\$204,300		\$0			
Trinity \$100,000	FY 08/09	\$25,000	\$0	\$0	\$0	\$25,000	\$0	6/24/2010	\$1,250	8/4/2010		
	FY 09/10	\$25,000	\$0	\$0	\$0	\$25,000	\$0	6/24/2010	\$1,250	8/4/2010		
	FY 10/11	\$25,000	\$0	\$0	\$0	\$25,000	\$0	6/24/2010	\$1,250	8/4/2010		
	FY 11/12	\$25,000	\$0	\$0	\$0	\$25,000	\$0	6/24/2010	\$0			
Tulare \$1,928,400	FY 08/09	\$482,100	\$0	\$0	\$0	\$0	\$482,100		\$0			
	FY 09/10	\$482,100	\$0	\$0	\$0	\$0	\$482,100		\$0			
	FY 10/11	\$482,100	\$0	\$0	\$0	\$0	\$482,100		\$0			
	FY 11/12	\$482,100	\$0	\$0	\$0	\$0	\$482,100		\$0			
Tuolumne \$193,200	FY 08/09	\$48,300	\$0	\$0	\$0	\$0	\$48,300		\$0			
	FY 09/10	\$48,300	\$0	\$0	\$0	\$0	\$48,300		\$0			
	FY 10/11	\$48,300	\$0	\$0	\$0	\$0	\$48,300		\$0			
	FY 11/12	\$48,300	\$0	\$0	\$0	\$0	\$48,300		\$0			
Ventura \$3,339,200	FY 08/09	\$834,800	\$0	\$0	\$0	\$0	\$834,800		\$0			
	FY 09/10	\$834,800	\$0	\$0	\$0	\$0	\$834,800		\$0			
	FY 10/11	\$834,800	\$0	\$0	\$0	\$0	\$834,800		\$0			
	FY 11/12	\$834,800	\$0	\$0	\$0	\$0	\$834,800		\$0			
Yolo \$832,800	FY 08/09	\$208,200	\$0	\$0	\$0	\$208,200	\$0	6/21/2010	\$10,410			
	FY 09/10	\$208,200	\$0	\$0	\$0	\$208,200	\$0	6/21/2010	\$10,410			
	FY 10/11	\$208,200	\$0	\$0	\$0	\$208,200	\$0	6/21/2010	\$10,410			
	FY 11/12	\$208,200	\$0	\$0	\$0	\$208,200	\$0	6/21/2010	\$0			
Totals		\$160,000,000	\$1,032,000	\$0	\$11,547,100	\$44,751,100	\$99,873,500		\$1,721,880			

¹Option 1 pursuant to IN 10-06: County delegates authority for the administration of PEI Statewide Funds to a Joint Powers Authority (JPA) for the implementation of "statewide programs".

²Option 2 pursuant to IN 10-06: County provides PEI Statewide Funds or other resources to a multi-County collaborative to implement "statewide" or "replicable" programs.

³Option 3 pursuant to IN 10-05 and IN 10-06: County assigns PEI Statewide Funds to DMH to implement "statewide programs" pursuant to DMH Info. Notice No.: 08-25 or any subsequently issued Information Notice that supersedes 08-25.

⁴Counties approved by Mental Health Services Oversight and Accountability Commission to use their funds locally.

Highlighted Counties request are on hold pending submission of FY 08/09 Revenue and Expenditure Report or until further notice.

NEW COUNTY MEMBERSHIP APPLICATION(S)

Agenda Item 6.A.

SUBJECT: CalMHSA New County Membership Application(s)

BACKGROUND AND STATUS:

During each Board meeting, the staff and members shall update the Board on the status of prospective new members. Additionally, staff has developed a spreadsheet to track activity of members and prospective members (See consent item C).

Staff will provide any updates from perspective members at the meeting.

RECOMMENDATION:

Approve membership to CalMHSA for applying County(ies).

REFERENCE MATERIALS ATTACHED:

- None

PROGRAM MATTERS
Agenda Item 7.A.

SUBJECT: Report from CalMHSa Program Director – Edward Walker

BACKGROUND AND STATUS:

During each Board meeting, Mr. Edward Walker, CalMHSa Program Director, will provide a verbal report on the status regarding stakeholder input as well as an update on the Implementation Ad Hoc Committee.

The Implementation Ad Hoc Committee met on August 19, 2010 to discuss a timeline for analysis of stakeholder input, priority selection and RFP/RFQ/RFA posting, reviewing and awarding (see attached timeline). On September 3, 2010 the committee will meet again at which the timeline will be refined. (An amended Timeline and Priority of Recommended Actions with the Summary Report of Stakeholder Input will follow under separate cover by Sept. 7, 2010.)

RECOMMENDATION:

Approval of the proposed ad hoc committee recommendations regarding the following:

- i. Implementation Timeline
- ii. Priority of Recommended Actions

REFERENCE MATERIALS ATTACHED:

- Ad Hoc Committee Meeting Notes, August 19, 2010
- Ad Hoc Committee Meeting Notes, September 3, 2010
- Implementation Timeline
- Summary Report of Stakeholder Input



"A George Hills Company Administered JPA"

California Mental Health Services Authority
Implementation Ad Hoc Committee
Meeting Notes from August 19, 2010

Meeting Start at 3:04 p.m.

Members Present:

Wayne Clark, PhD, Monterey County
William Arroyo, MD, Los Angeles County
Karen Baylor, MFT, PhD, San Luis Obispo County
Maureen Bauman, LCSW, Placer County
Anne Marie Rucker, MFT, Sacramento County
Michelle Callejas, LCSW, Sacramento County

Staff Present:

John Chaquica, CalMHSA
Edward Walker, CalMHSA
Laura Li, CalMHSA
Maya Maas, CalMHSA

Stakeholders Present:

Betsy Sheldon, California Community Colleges, Chancellor's Office
Amber Burkan, CA Youth Empowerment Network (CAYEN)
Ralph Metzger, United Advocates for Children and Families
Lin Benjamin, CA Department of Aging
Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)
Vivian Criado, California Elder Mental Health and Aging Coalition
Delphine Brody, California Network of Mental Health Clients
Kathleen Derby, National Alliance on Mental Illness (NAMI California)
Stephanie Welch, California Mental Health Directors Association
Zoey Todd, CA Department of Mental Health

Meeting Start 3:04pm

The chair called the meeting to order followed by an overview of the meeting process, after which the chair asked everyone to introduce themselves.

1. Ad Hoc Workgroup Tasks and Timeline

The chair, Dr. Clark, preceded with giving an outline of the timeline described in the agenda thru item one.

Dr. Baylor voiced that this was an aggressive timeline and as such should probably schedule a whole day for the November Board meeting and staff will give a proposal for a November meeting date.

Ms. Bauman echoed Ms. Baylor's comments.

2. Implementation plan now called Strategic Plan in three phases

Dr. Clark did a review of the implementation plan and stated it was prudent to do this in three phases as opposed to all at once. After his review he opened it up for discussion.

Ms. Rucker asked for purposes of applying for these competitive bids would it be counties or agencies?

Dr. Clark stated that it could be both.

Ms. Bauman felt that it was premature to determine at this point in time and they would see how things rolled out before deciding that.

Dr. Clark added that it would be helpful if everyone, including stakeholders, would take the time to re-read the three strategic plans so that they are familiar with them and like him, would notice that Student Mental Health Higher Education gets 75% of the funds and K-12 gets 25%. This also allows for everyone to ensure that the guidelines are being followed.

Dr. Baylor asked who the contract would be with, the JPA or George Hills?

John Chaquica, CalMHSA, clarified that the contract would be between the JPA and selected providers.

Dr. Baylor asked if a 30 day posting was required and when the RFQ process would take place, to which Dr. Clark confirmed the requirement of a 30 day posting which would take place on October 7, 2010 with further discussions on RFPs in

September.

Ms. Bauman voiced how the 30 day process would come about rather quickly for the 2 & 3 proposals, pending RFPs, and the potential that you could have it out a little sooner without changing the return date just to give folks out there a little more time. Again, not change the returning date.

Dr. Clark clarified it was possible that every 15 days for the first 3 phases you could do the RFP or RFQs but the timeline as far as when they are reviewed would still have those due dates.

Dr. Arroyo echoed Ms. Bauman's comments and raised a question as to how the order of initiatives came about and felt that Stigma and Discrimination Reduction could go first which would allow for learning from that process as they move forward with the others.

Dr. Clark indicated phase 2 could be moved up, but Suicide Prevention was identified as the most certificated and comprehensive of the three programs and therefore, is why it was selected to go first. Also added the difference between phase 1 and 2 is only 15 days so there really isn't much to move up.

Dr. Baylor echoed Dr. Arroyo's comments and asked that they really look at which initiative should be rolled out first. She was concerned with waiting too long to implement Student Mental Health, which would probably take place at the end of the school year delaying services to students.

Dr. Arroyo thanks Dr. Clark for pointing out the difference between the two phases being 15 days, which was shorter than he expected, therefore has less of a concern.

Betsy Sheldon, California Community Colleges, echoed Dr. Baylor's concerns.

Kathleen Derby, NAMI California, expressed her preference in implementing Suicide first which could form a foundation for the others.

Ms. Sheldon added that it was important to note that some of these programs could address more than one initiative and should take this opportunity to do something innovative by overlapping or leveraging some of these programs.

Delphine Brody, California Network of Mental Health Clients, echoed in support of Stigma being implemented first.

Viviana Criado, California Elder Mental Health and Aging Coalition, asked if these

resources allowed for other languages?

Ms. Bauman and Dr. Clark agreed that the plan is to use English only in the RFP process, but could have some translation in the actual projects.

Edward Walker, CalMHSA, reminded everyone that the source documents were not translated and DMH does not have a ready solution for translation.

Dr. Arroyo felt it important to have the two less developed plans drafted by staff in an easy to follow format for the general public.

Dr. Clark reiterated their intent to make it a clear and efficient process.

3. **Implementation Plan/Strategic Plan**

Key Structural Features:

Dr. Clark gave a review of the key structural features and implementation tools by strategic plan followed by opening it up for comment.

A question was raised as to proportionality of funds and how that would be done.

Mr. Walker stated that it means in general to hold within that proportionality range as sited in the OAC Guidelines, which does not have to be penny proportionality.

Dr. Clark clarified, if there is X amount of dollars in Stigma, X amount in Suicide and X amount in Student Mental Health then, per Mr. Walker, you stay generally within that proportionality range.

Mr. Walker added a rationale for the variance could be presented to the OAC if divergence from general proportionality seemed necessary.

Dr. Baylor asked how this would be done as counties are still joining.

Mr. Walker explained that by time they get to this stage or by end of November it is expected that large percentage of counties will have already joined.

Dr. Clark confirmed that whatever is in the bank is what they move forward with a proportional basis.

Dr. Arroyo asked Mr. Walker at the end of the calendar year what percentage of the potential pool will be available?

Mr. Walker and Dr. Clark estimated it would be approximately 75% of the resources in the JPA but not 75% of counties in the JPA.

Implementation tools by strategic plan:

Dr. Clark pointed out the implementation tools by strategic plan would take some work in the next 6-8 weeks and a lot will be done by George Hills staff and looking at least competitors. He clarified that the scope of work defines the RFP, RFQs and will be looked into by legal counsel to ensure compliance and appropriateness.

Ms. Bauman advised, based on past experience, doing the scope of work and rubric scoring simultaneously as rubric will help guide the scope of work.

Dr. Arroyo offered to share their conflict of interest and staff was directed to contact Dr. Arroyo to obtain copies.

Ms. Benjamin, CA Department on Aging, asked if the conflict of interest included CalMHSA members.

Dr. Clark agreed that it would include members and again would seek guidance from legal counsel.

Ralph Metzger, United Advocates for Children and Families, asked if members were allowed to bid on an RFP.

Dr. Clark indicated that legal counsel would research and determine what was plausible.

4. Evaluation

After review of the evaluation process Dr. Clark opened it up for discussion.

Dr. Baylor questioned where the funds were to coming from for the evaluation.

Mr. Chaquica confirmed that the evaluation was to be included within the 15% allocation.

Ms. Bauman indicated that there was a need to identify a statewide organization to do an evaluation.

Mr. Walker directed everyone to page 7 of the OAC guidelines regarding evaluation.

Ms. Benjamin asked if this should be brought back to the OAC's attention for

further communication.

It was mentioned that a statewide evaluation should be part of the larger plan.

Staff to meet with the OAC for clarification on evaluations.

5. Meeting Wrap Up

Ms. Hiramoto, Racial & Ethnic Mental Health Disparities Coalition (REMHDCO), voiced concerns with the timelines for approval on implementation plans from the OAC, as they do not meet in December.

Dr. Clark was not aware of OAC's meeting calendar and asked that staff coordinate with the OAC to ensure the timeline will work for all.

Ms. Benjamin asked if there was another review for stakeholders input.

Dr. Clark stated that the next meeting would include a summary of the already collected stakeholder input on September 3rd.

Hearing no further comments the meeting was adjourned at 4:23pm.



"A George Hilli Company Administered JPA"

CalMHSA Implementation Ad Hoc Committee

Teleconference Notes from September 3, 2010

The teleconference start time: 11:05 am

Roll Call:

Karen Baylor, PhD, San Luis Obispo
Maureen Bauman, LCSW, Placer County
Wayne Clark, PhD, Monterey County
William Arroyo, MD, Los Angeles County
Edward Walker, CalMHSA
John Chaquica, CalMHSA
Laura Li, CalMHSA
Maya Maas, CalMHSA
Ann Marie Rucker, Sacramento County
Katherine Scroggo, Sacramento County
Viviana Criado, California Elder Mental Health and Aging Coalition (CEMHAC)
Amber Burkan, CA Youth Empowerment Network (CAYEN)
Sandra Black, Department of Mental Health
Zoey Todd, Department of Mental Health
Dee Lemons, Mental Health Services Oversight and Accountability Commission
Stephanie Welch, California Mental Health Directors Association (CMHDA)
Sandra Naylor Goodwin, California Institute Mental Health (CiMH)
Deretha Flournoy, California Institute Mental Health (CiMH)
Betsy Sheldon, California Community Colleges, Chancellor's Office
Delphine Brody, California Network of Mental Health Clients

Wayne Clark, PhD, Monterey County, chaired the meeting and commenced by going over the process in which the teleconference would proceed to include a review of the

implementation timeline and summary report followed by future meetings. He added member comment would be first followed by a stakeholder comment period.

Dr. Clark started by asking that Edward Walker, Program Director, commence by giving an overview of the timeline. Mr. Walker summarized the timeline as the only change was the December date for OAC review and approval of the final work plan.

Dr. Clark indicated time is critical since as there is a lot to be done during the next six weeks, including the posting of a draft work plan and review process in October; and posting of input on implementation plan in November followed by seeking approval in the final work plan the first week of December. Preparing for the RFP process will need to be done.

Dr. Clark asked for comment as it relates to the work plan implementation phase being Dec. 15th, Dec. 30th and Jan. 14th. He felt that this timeline may be a bit aggressive but it reflected two vortexes: a need for urgency and a need for reality.

William Arroyo, MD, Los Angeles County, stated that the release of RFP/FRQ's during the holiday season would be at best a cumbersome one and asked what would be the implications for postponing that a one month delay? Dr. Arroyo suggested a delay of one month, or January 15th.

Dr. Clark asked for comments from other members.

Karen Baylor, PhD, San Luis Obispo, agreed with Dr. Clark's previous comments of the two vortexes's and is torn by wanting to get these programs off the ground and fact that people will be out during the holiday season.

Following discussion by Maureen Bauman, LCSW, Placer County, Dr. Arroyo and Dr. Clark, it was agreed that a 2 week adjustment to the timeline was necessary. Staff will revise the RFP timeline to begin the first week of January instead of mid- December.

Deretha Flournoy, CiMH, reminded all Jan 1st was a Saturday.

Mr. Walker assured there would be an approximate 15 day adjustment would account for weekends and holidays.

Viviana Criado, asked if the November 4th date was for input to which Dr. Clark clarified that it would not be on that date, but on October 7th when stakeholder input would be requested.

Dr. Clark stated as they moved along with the development of the implementation plan it was their hope that stakeholders would participate.

Dr. Clark moved to review of the draft summary report structure.

Dr. Clark stated that a tremendous amount of work was put into putting the report together and noted he wasn't sure they were done using the data that was provided, but directed everyone to the CalMHSA website so that they could view the input submitted.

Dr. Clark thanked staff and all participants for input provided.

Mr. Walker explained the layout of the report including the background and text part of the report followed by several appendices. He added that a large amount of input came in on the 31st and was yet to be posted, but assured it would be done by the weekend.

Mr. Walker oriented the committee to the report structure. He noted that an error was made on page 10 in the K-12 strategic direction, which will be corrected.

Ms. Bauman clarified that the strategic directions were prioritized not the actions in the summary of the report.

Dr. Clark indicated available resources will shape priorities. Other items on Appendix One can be initiated later as money comes in.

Dr. Arroyo added that Mr. Walker could do some fine tuning or editing of the amounts reflected on top of each of the strategic plans on appendix one. Example: Suicide Prevention should read "up to a maximum of \$40 million"). He also recommended splitting up student mental health as they each receive different amounts.

Mr. Walker said a revised report would be completed on Tuesday for distribution to the Board.

Dr. Clark added it would be a good idea to have a high and low range on the appendices as well. He asked if there were any other comments as it relates to the structure of the report.

Dr. Arroyo added the great work by staff in putting this together.

After no further comment, Dr. Clark asked for stakeholder comment.

Delphine Brody, Client Network, stated her concern for the themes being overly simplistic and causing loss of their concerns.

Dr. Clark reiterated that there were rich set of materials sent by many stakeholders and as they could not include all comments, they therefore tried to summarize. But when it

comes to the work plan those themes, comments would come into play in developing the work plan.

Dr. Clark indicated if Ms. Brody has those comments in her submissions, there was no guarantee, but was confident they would be included as part of the description in peer-to-peer orientation.

Ms. Criado echoed Ms. Brody's comments and felt that the information was very general but understood and wanted to make it clear her desire for emphasis to represent age specific.

Dr. Clark clarified when speaking of diversity that ageism is also mentioned amongst all of the other -isms, to which Ms. Criado responded in the affirmative.

Hearing no other comments regarding to structure, Dr. Clark moved forward with the prioritization, commencing with "create a system of suicide prevention."

Dr. Baylor mentioned some of the recommended actions were pretty lofty, which is how some of the thought went into which recommended actions to include and not.

Dr. Clark read the priority order of the strategic directions from Suicide Prevention and asked if there was comment from any of the members.

Dr. Arroyo asked if there was a need to clarify the heading (recommended actions). To He recommended a foot note be added to reflect the upper tier of recommended actions.

Ms. Bauman added it could be "initial recommended actions," so that it is clear somewhere.

Sandra Black, Office of Suicide Prevention, stated in the development of the three plans there were components that would reflect system partners and the local level, therefore, some recommended actions would not be appropriate for a state-wide project.

Dr. Clark listed the priorities selected under Suicide Prevention then asked for comments.

Ms. Criado, asked for the possibility of collapsing some of the recommendations into one because she noted time is of the essence and in looking at the recommended actions selected, she doesn't know how you could do 4.2 and 4.3 without doing 4.1, therefore, do them all.

Ms. Black echoed the comment made by Ms. Criado and added the need to get data from various sources as opposed to just one source to have a complete and clear idea.

Ms. Brody commented on whether a differential weight given to the breakdown of submissions or how did this come about?

Dr. Clark explained they were not counted equally, but themes were to see how they fit with the strategic plan that was already in place so you could then from there prioritize which activities could be funded in the first phase of this process. There is no statistical or economical formula.

Ms. Brody voiced her concern for loss of input given at the initial process.

Dr. Clark asked staff to look at 4.1 and made it clear this needs to be as data-driven as possible.

Ms. Criado added the need to also look at attempts of suicide, which they know very little about and which are more prevalent than death.

Dr. Clark stated the need for better data than can be provided and hearing no further comments asked they move forward with Stigma and Discrimination Reduction.

Dr. Clark reviewed the strategic directions and asked for comment relating to the order.

Amber Burkan, CAYEN, commented when moving forward to look at gaps in groups who did not submit, such as transition age youth (TAY), because there seems to be a lot of themes arising with a focus on Elder Adults, again a need for acknowledging those gaps.

Dr. Clark moved forward with reviewing the recommended actions for Stigma and Discriminations and asked for comments.

Zoey Todd, Department of Mental Health, voiced her concern with the many activities and themes that are overlapping and how they weave together in addition to how the RFPs will encourage that cross connection.

Dr. Clark indicated Ms. Todd had a good point and would take into account her concerns and confirmed it would be a challenge they expected and would work toward achieving those connections.

Ms. Brody noted the votes in Appendix One did not match with the selected priorities on page 7 and asked how that selection came about.

Dr. Clark reiterated not to compare the selected priorities with the votes on Appendix One as some recommended actions address more than one priority; therefore, not

there was not a need to select as many. The priorities do not necessarily reflect the votes.

Ms. Brody asked there be more clarity as to how priorities are being selected as they were pursuing 1.6, 1.8 and 1.4 and these are not selected as a priority.

Dr. Clark asked for comment from the members as to adding some of the priorities mentioned by Ms. Brody.

Dr. Baylor gave an example of 1.5 and indicated when doing the scope of work, how is that going to be operationalized? This is why 1.1 was chosen as it encompasses 1.5 and would be easier to solicit an RFP.

Ms. Brody voiced 1.5 addressed the issue of recognition as there is little or none, thus being a priority.

Ms. Todd had a question as to where they are in this, if they look at 1.5 and it has eight or so bullets under it on how you would recognize and support peer lead or run programs and it is clearly a very import piece of this and happening in many counties but not sure if it is not on this page does that mean it will not going to be in the RFP/RFQ?

Dr. Clark indicated this being a draft put together by staff and this meeting being about getting input from everyone to make any necessary changes they felt important. He added there were more steps to this process, the work plan and then the RFPs, which logically you could say if it's not in here it would not end up in the RFP, but at the same time when you think of the detail, then surely it would be. Again, if it is a great concern, then voice them so they can be added back in.

Ms. Bauman again indicated the challenge is not everything can be done.

Dr. Arroyo echoed Ms. Bauman's comment and stated the plan was developed with no budgetary constraints but the reality is it can't be done. Therefore, this is the initial effort to identify those priorities, which is what this meeting is about.

With that, Dr. Clark asked members if they wanted to add 1.5, 1.6 and 1.8 to the priorities already selected, per stakeholder request.

Ms. Bauman supported that additional language be added in the form of a motion.

Dr. Clark asked for a second; no second was made.

Dr. Baylor indicated she could not support that motion as she felt she needed to research further and added there had been a lot of work with 1.8 and seemed like it was a duplication and don't want to duplicate efforts.

Stephanie Welch, CMHDA, addressed Ms. Brody and asked when advocating for 1.5 and 1.8 she was surprised she did not include 1.5 because it is identified in the strategic plan as one of the evidence-based practices to reduce stigma. Speaking on the research she has done in her career, she recommended that 1.5 be added to the inclusion of priorities.

Dr. Baylor referred to page 44 of the strategic plan and, after further review, agreed to amend her previous position by agreeing to the addition of 1.5 and 1.6 to the priorities.

Betsy Sheldon, California Community Colleges, Chancellor's Office, echoed Ms. Welch's comments in adding 1.5 to the priorities.

Ms. Todd, Ms. Burkan & Ms. Criado echoed the addition of 1.5 and 1.6.

Ms. Bauman made an amendment to her previous motion to add 1.5 and 1.6 to the priorities.

Dr. Clark reiterated to put 1.5 and 1.6 in prioritization to the strategic direction on creating a supportive environment for consumers.

Dr. Baylor seconded the motion.

Ms. Brody wanted to ensure they didn't lose sight of 1.8 as it is a higher priority for them.

Dr. Baylor acknowledged the previous comment and added it would be appropriate to have it as a priority at the next phase rolled out and Dr. Arroyo agreed.

Ms. Todd added that 1.8 looked misplaced and wondered if it could be addressed under 1.6.

Dr. Clark added some work could be done with that once they put the work plan together.

Ms. Burkan indicated 2.3 as being important but not currently one of the priorities.

Dr. Clark indicated the reason for that is because it was clearly included in the student initiative.

After no further comment, Dr. Clark moved on with review and student mental health. He stated there were no changes and the section is all inclusive as written.

Ms. Sheldon voiced her concern for the last sentence which reads “a system within one” and the update with the initiative clearly states the intent that programs would be developed within each of the three public higher education systems.

Dr. Clark ensured that would be corrected.

Ms. Sheldon added comment regarding themes under this section and wanted the acknowledgement of “gatekeeper,” as an important component. The other item she felt was missing was the Crisis Response teams (CIT), which are widely used. She was referring to the model not the program necessarily.

Dr. Clark stated that these things are important and welcomed Ms. Sheldon’s participation when developing the work plan.

Ms. Todd stated the problem with #2 of K-12 was there are many programs that are not coordinated. They are fragmented and she emphasized they be sure to try and find models and implement pilot programs that actually integrate a whole school climate comprehensive approach.

Dr. Clark again reiterated the importance of bringing this to-light in the work plan.

With no further comment, Dr. Clark asked the staff to redraft this report for review by the Board next week.

Dr. Clark wrapped up by indicating they needed to set some future meeting dates, which were set as follows:

September 7 th	Distribution of Revised Summary Report
September 17 th , 8:00am – 9:00am	Ad Hoc Committee Meeting
October 4 th , 4pm – 5pm	Ad Hoc Committee Meeting
October 7 th	Work plan submitted for review

Ms. Sheldon asked where they would send any corrections they felt necessary, to which, Mr. Walker indicated corrections should be forwarded to Laura Li.

Hearing no further comments, Dr. Clark adjourned the meeting at 12:52 pm.



California Mental Health Services Authority
Implementation Ad Hoc Committee

Please Note: In order to facilitate timely communication and seamless review process, MHSOAC requests that we use the standard terms familiar to staff and Commissioners: (1) work plan instead of strategic plan (concerned that the three published Statewide PEI Strategic Plans would be confused with CalMHSA implementation plan); (2) program instead of component for the phased implementation of the three Strategic Plans.

TIMELINE

- August 19: Ad hoc workgroup convenes with Stakeholder participation
- August 31: last date for submission of stakeholder input;
-
- September 3: Ad hoc workgroup convenes with Stakeholder participation to review CalMHSA staff summary, and categorization of stakeholder input, summary report published
-
- September 10: Board meeting: review summary report findings and implementation timeline (see #2 below)
- September meetings of Ad hoc committee established to review:
 - Outlines for RFP, RFQ, RFA, scope of work,
 - Procedures for establishing review panels and review criteria
 - Drafts of proposed Work Plan
- October 7: Board agenda and draft Work Plan posted
- October 14: Board meeting: draft Work Plan reviewed
 - Ad hoc committee workgroup activities presented
- November 4: Board agenda and implementation plan input posted

- November Board meeting (TBD):
 - **FINAL WORK PLAN** presented for approval
 - Overarching implementation approach that describes key implementation phases and tools to be used (i.e., RFP/RFQ/RFA/Non-competitive).
 - Analogous to a CSS or PEI plan approval with sequence and segments described that are implemented subsequent to plan approval
- November 15: MHSOAC submission for staff analysis; DMH submission for review
- December 9 (tentative): MHSOAC meeting (telephone) reviews for approval

Work Plan implemented in three phases

- January 5: **Phase One**: release program plan for suicide prevention RFP/RFQ/RFA due 30 days
 - February 7: Review Panel convenes; recommends selection
 - March 3: Board agenda posted.
 - March 10: present selection for Board approval
 - March 31: contract negotiations concluded and contract finalized; implementation begins
- January 17: **Phase Two**: release program plan for stigma RFP/RFQ/RFA due 30 days
 - February 21: Review Panel convenes; recommends selection
 - March 3: Board agenda posted.
 - March 10: present selection for Board approval
 - March 31: contract negotiations concluded and contract finalized; implementation begins
 -
- February 2: **Phase Three**: release program plan for student mental health initiative RFP/RFQ/RFA due 30 days
 - February 21: Review Panel convenes; recommends selection
 - April 7: Board agenda posted.
 - April 14: selection for Board approval
 - May 6: contract negotiations concluded and contract finalized; implementation begins

Work Plan Implementation

- key structural features:
 - Statewide with regional/local relevance
 - Regional/local with statewide relevance
 - Funding proportionality across the three strategic plans
- Implementation tools by program plan:
 - RFP/RFQ/RFA/Non-competitive:
 - Scope of work
 - Scoring rubric
 - Review panel composition

Evaluation

- Implementation overall by program plan
 - Specify that participation in statewide evaluation required of all proposals.
- By component of implementation phases (i.e., for SP statewide media campaign concurrent with one or more regional county collaboratives)
- Statewide evaluation RFP/RFQ/RFA:
 - Projected for February – March 2011
 - Date TBD: Review Panel convenes; recommends selection
 - Date TBD: Board Agenda posted
 - Date TBD: Selection for Board approval
 - Date TBD: Contract negotiations concluded and contract finalized; implementation begins

California Mental Health Services Authority

SUMMARY REPORT

**Stakeholder Input and Recommendations for
Statewide Implementation of
California Strategic Plans on Suicide Prevention,
Stigma and Discrimination Reduction, and
Student Mental Health Initiative**

September 10, 2010



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Background

At its June 10, 2010 meeting, the California Mental Health Services Authority (CalMHSA) Board established an Implementation Ad Hoc Committee for planning and implementation of the three Strategic Plans on Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health for Statewide Prevention and Early Intervention:

The Implementation Ad Hoc Committee is charged with determining a method for the selection of priorities in the development of implementation plans for statewide PEI programs. Committee members will recommend to CalMHSA Board guidelines and protocols in compiling, analyzing and reporting on the stakeholder input being gathered prior to the August 31, 2010 deadline. Implementation planning will be concurrent to the stakeholder input process and completed following the September 10, 2010 Board meeting.

On July 7, 2010, CalMHSA publicly posted the Stakeholder Input Planning Process for Statewide Prevention and Early Intervention. Stakeholder input was to be submitted in writing by email attachment, facsimile transmission or hard copy within 30 days. A step-by-step submission procedure was posted with the Planning process on the CalMHSA website. Stakeholder input templates were available for each of the three Strategic Plans. At the July 2010 meeting of the CalMHSA Board, following public and stakeholder comment, a Planning Process was approved with an extended submission period for submitting stakeholder input to August 31, 2010. Staff created a summary report template in which stakeholder input was inserted as it was received. Staff sorted the input by strategic plan and recorded the suggested priorities. General stakeholder comment was sorted by strategic direction. General themes reflecting the three State Strategic Plans were identified. Input was posted weekly on the CalMHSA website to be accessible to all interested parties.

The CalMHSA Ad Hoc Implementation Committee met via teleconferencing on July 27, 2010, to review Committee charge and implementation timeline. Responding to requests, subsequent meetings held on August 19th and September 3rd included stakeholder participation, which continued as CalMHSA developed the proposed timeline, reviewed the draft Summary Report, and will be sustained throughout the remainder of the Ad Hoc Committee meetings.

Report Introduction and Overview

This Report contains two distinct sections: the recommendations and priorities for each statewide Strategic Plan and an Appendix, which presents details on Stakeholder input.

The first section presents priorities for implementing the recommended actions of the California Strategic Plans on Suicide Prevention, Stigma Reduction and Student Mental Health Initiative. This Report is also framed by the Mental Health Services Oversight and Accountability Commission's Guidelines for Statewide Prevention and Early Intervention (PEI) Programs, which requires obtaining stakeholder input on setting priorities for the Recommended Actions. This requirement was met by the following method(s):

- CalMHSA conducted a 52-day public comment process to solicit in writing stakeholders' recommended priorities and other comments. It should be noted that each of the three plans were the result of extensive statewide stakeholder input process, leaving a strong foundation of recommendation from which to build the implementation plan.

The three appendices provide detailed stakeholder input for reference:

- Appendix 1: *Strategic Directions and Recommended Actions* are arrayed with Stakeholder input, which is summarized and tabulated.
- Appendix 2: Summary by organization, individual and locality of stakeholder submissions.
- Appendix 3: General themes that emerged from stakeholder input.

Principles and Policy Directions

- Each Statewide initiative should be complementary to the other initiatives (e.g., Suicide Prevention initiative should address how its design complements stigma/discrimination reduction and vice versa) and should complement other state, regional and local resources.
- If a regional effort is prioritized, the program should not be in the same funding priority category or program as, for example, a statewide media campaign;
- All initiatives should be culturally and linguistically competent, respectful and inclusive of California's diverse population.
- All initiatives should have a life span appropriate focus for children, transition age youth, adults, and older adults.
- All initiatives should address California's geographical diversity ranging from small communities spread over large rural areas to metropolitan areas with suburban expanse and urban density.

- Available resources will limit the scale of implementation.
- All initiatives should optimally leverage federal, state and local resources.
- Implementation expenditure proportionality: MHSOAC Guidelines, page 6: “it is the intent of the MHSOAC that the expenditure of PEI Statewide Funds be consistent with the general proportion of funds originally intended for the three program areas as identified in Planning Estimates provided in DMH Information Notice No.: 08-25: Suicide Prevention 25%; Stigma and Discrimination Reduction 37.5%; and Student Mental Health 37.5%.”

CalMHSA Implementation Summary and Prioritization of Recommendations

STAKEHOLDER INPUT BY STRATEGIC PLAN

Below is a summation of Stakeholder inputs received on the Recommended Actions¹ arranged in thematic categories. It should be noted that although we are counting number of times mentioned, we are doing so merely to identify relative volume. Organizing stakeholder comments by themes, especially as they mirror the original strategic plan, allows us to present relative areas to prioritize. (To clarify, priorities were not weighted by vote; rather themes were identified from comments to help prioritize.) Appendices 1, 2, and 3 provide more aggregate and differentially displayed detail on stakeholder input. The Summary Report priorities presented below do not represent CalMHSA’s final implementation work plan. The central purpose of the Summary Report is to present stakeholder input. The final work plan submitted to the MHSOAC will feature a complementary implementation design for the Statewide PEI Strategic Plans that also establishes appropriate linkage with local PEI programs.

California Strategic Plan on Suicide Prevention:

Maximum Allocated Funding for Suicide Prevention	
Annual: \$10 Million	Total Four-Year Funding: \$40 Million
Projected Funds Available: 60—75% of Maximum	
Annual Range: \$6—\$7.5 Million	Total Four Year Funding Range: \$24—\$30 Million

Theme and Priority One: Create a System of Suicide Prevention

Recommended actions:

1.3	Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. (list of partnerships)
1.4	Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.

¹ This Summary Report acknowledges the vision and values of the three Strategic Plans and the stakeholder and professional contributions to each plan.

1.5	Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level, and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.
1.6	Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.
1.11	Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders, and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.
1.12	Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems.
1.13	Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

Illustrative Themes:

- Preserve and build accredited hotlines
- Friendship Line for the Elderly
- Develop programs that reduce or eliminate service gaps for historically underserved racial and ethnic groups
- Establish a working group to address the needs of elders
- Coalitions should be comprised of consumers, family members, service providers

Theme and Priority Two: Educate Communities to Take Action to Prevent Suicide

Recommended actions:

3.2	Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.
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3.3	Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness, and mental health services that support suicide prevention efforts.
3.7	Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.
3.8	Educate family members, caregivers, and friends of those who have attempted suicide, individuals who have attempted suicide, and community helpers to recognize, appropriately respond to, and refer people demonstrating acute warning signs.
3.9	Promote and provide suicide prevention education for community gatekeepers.
3.11	Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer crisis respite centers, as a part of suicide prevention and follow-up services.

Illustrative Themes:

- Communication to the public through “gatekeeper” programs
- Develop online tools...for reaching a sizable diverse population”
- Build social connectedness
- Provide accessible mental health services for the blind and visually impaired
- Implementation of an age-appropriate, multi-language education campaign

Theme and Priority Three: Implement Training and Workforce Enhancements to Prevent Suicide

Recommended actions:

2.1	Convene expert workgroups to recommend, develop, disseminate, broadly promote, and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.
2.2	Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, graduate.

2.5	Increase the priority of suicide prevention training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs.
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Illustrative Themes:

- New knowledge to be integrated into protocols in training and curricula
- Faculty training (“Help, I’m an educator, not a therapist” program)
- Hotline staff trained to intervene with callers of all ages
- Training required for licensed/credentialed professionals working with older adults
- Gun safety education and safe medication storage

Theme and Priority Four: Improve Suicide Prevention Program Effectiveness and System Accountability

Recommended actions:

4.2	Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.
4.3	Identify or develop methodologies for evaluating suicide prevention interventions, including community- based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.
4.5	Increase local capacity for data collection, reporting, surveillance, and dissemination to inform prevention and early intervention program development and training.
4.6	Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.

Illustrative Themes:

- Improve data collection, surveillance, program evaluation and research
- Establish elder-death review teams in every county

California Strategic Plan on Stigma and Discrimination Reduction:

Maximum Allocated Funding for Stigma and Discrimination Reduction	
Annual: \$15 Million	Total Four-Year Funding: \$60 Million
Projected Funds Available: 60–75% of Maximum	
Annual Range: \$9—\$11.3 Million	Total Four-Year Funding Range: \$36—\$45 Million

Theme and Priority One: Creating a supportive environment for all consumers and those at risk for mental health challenges, family members, and the community at large establishing social norms that recognize mental health is integral to everyone's well-being.

Recommended actions:

1.1	Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis; and persons living with mental health challenges have resilience and the capacity for recovery.
1.5	Recognize peer run and peer led programs as an important means for reducing stigma.
1.6	Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.
1.7	Provide increased support for those closely involved with the lives of individuals facing mental health challenges.

Illustrative Themes:

- Expansion of crisis residential programs and integrated community services teams
- Increased uses of non-traditional cultural approaches
- Training for senior and college housing staff, subsidized housing providers
- Skill acquisition for multicultural house residents
- Anonymity of services at student health centers

Theme and Priority Two: Promoting awareness, accountability, and changes in values, practices, policies, and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges.

Recommended actions:

2.1	Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices, and policies.
2.4	Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care, and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faithbased practices as tools for wellness and recovery.
2.6	Educate employers on the importance of mental health wellness for all employees.
2.9	Engage and educate the commercial, ethnic, public/community, and interactive media, as well as the entertainment industry, on standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and ways to serve as a resource for communicating accurate and stigmatizing information to the public on mental health issues and community resources.
2.10	Promote and enhance initiatives, programs, and curricula to change school cultures and increase social inclusion and social acceptance.

Illustrative Themes:

- Ongoing education for criminal justice and legal professionals with close contact to children and adults with mental health challenges
- Education to correct the perception of who is entitled to receive services (e.g., immigrants)
- Primary care community education
- Peer educators
- Resource documents should be available in all languages

Theme and Priority Three: Increasing knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

Recommended actions:

4.1	Develop and implement a plan to address the information gaps on how to reduce stigma and discrimination to build effective and promising anti-discrimination programs.
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Illustrative Themes:

- Evidence based practices and training: California Brief Multicultural Scales
- New approaches to program evaluation
- Implementation of scientifically based information on how to effectively reduce stigma and discrimination early in life
- Measure effectiveness as progress is made
- Client reconciliation with family members to better understand the issues

Theme and Priority Four: Upholding and advancing federal and state laws to identify and eliminate discriminatory policies and practices.

Recommended actions:

3.1	Increase awareness and understanding of existing laws and regulations that protect individuals living with mental health challenges and their family members against discrimination.
3.4	Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.

Illustrative Themes:

- Heightened safety needs of seniors
- Ensure appropriate protective legal interventions
- Develop a policy assuring services to older adults

California Strategic Plan on Student Mental Health Initiative:

Maximum Allocated Funding for Student Mental Health Initiative	
Annual: \$15 Million	Total Four-Year Funding: \$60 Million

HIGHER EDUCATION

Maximum Allocated Funding for SMI Higher Education	
Annual: \$8.5 Million	Total Four-Year Funding: \$34 Million
Projected Funds Available: 60–75% of Maximum	
Annual Range: \$5.1 — \$6.4 Million	Total Four-Year Funding Range: \$20.4—\$25.5 Million

Theme and Priority: Design and administer programs that will focus on three key strategic directions: training, peer support activities and suicide prevention. Any college, district, multi-campus collaborative, or system within one of the three California public higher education systems would be eligible. Successful programs will be based on demonstrated need and will emphasize culturally relevant and appropriate approaches, linkages to local community MHSA Prevention and Early Intervention plans and/or Community Services and Supports plans, and collaboration with mental health and substance abuse prevention partners. It is the intent of the MHSOAC that programs will be established in each of the three public higher education systems.

Recommended actions:

1.	Training	The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness, and to promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community.
2.	Peer-to-Peer Support	These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment

		strategies, and reduction of the stigma associated with mental illness. Peeto- peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.
3.	Suicide Prevention	These programs would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students, and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.

Illustrative Themes:

- Events on college campuses (e.g., “In Our Own Voice”)
- Evidence-based best practice prevention approach
- Encouraging students holistic approach to their mental health
- Resist the temptation to provide one-time funding for a narrow program
- Focus on the goals of using grants to provide a model of systems change
- Utilizes a tiered response to intervention
- Focus specifically on addressing the unique needs, vulnerabilities and risk factors of the blind/visually impaired
- Cost effective, easily scalable and accessible method for supporting the mental health needs of students
- On-line technologies to facilitate peer-to-peer network
- Questionnaire used to screen for depression at primary care appointments (e.g., Patient Health Questionnaire called PHQ-9)

KINDERGARTEN THROUGH TWELTH GRADE (K-12)

Maximum Allocated Funding for SMHI Kindergarten Through Twelfth Grade	
Annual: \$6.5 Million	Total Four-Year Funding: \$26 Million
Projected Funds Available: 60–75% of Maximum	
Annual Range: \$3.9—\$4.9 Million	Total Four-Year Funding Range: \$15.6—\$19.5 Million

Theme and Priority: Design and administer programs that address the systemic challenges in providing a comprehensive approach to addressing student mental health. Successful programs will take the variety of discrete school-based mental health interventions and programs that have been proven effective and combine them into a comprehensive student mental health program.

Recommended actions:

1.	School-Based Programs: Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including:
	Efforts that foster supportive school climates including bullying prevention, suicide prevention, stigma reduction, and cultural awareness.
	Mental health educational programs for students that include a focus on stigma reduction, incorporate age- appropriate suicide prevention training for the general student population, and are in alignment with state Health Education Standards.
	Early identification of students with mental health concerns who seek help, including universal voluntary screenings in partnership with families and caregivers.
	Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs, and community-based organizations.
	Outreach and education for families that are culturally and linguistically responsive and reduce the stigma associated with accessing and using mental health services.
	Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for specific mental health needs, for example suicide risk among African-American and Caucasian males, Asian-American females, Hispanic males and females, LGBTQ youth and Native American youth.

	Training for those personnel, like teachers, most likely to first identify potential mental health needs, which includes resources for identification, referral, and non-stigmatizing responses.
	Use of appropriate youth peer-to-peer strategies.
2.	Systems and Policy Developments: Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include:
	Coordination and redirection of resources through school, district-wide, regional and/or statewide systems to create a cohesive and comprehensive system from prevention and early intervention to intervention and support for student mental health as opposed to fragmented programs.
	Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.
	Collaboration with community-based providers that enhance student success, for example health services, tutoring, after-school programs, or mentoring.
	Development of policies within the school/district/region/state that make mental health promotion an integral part of school operations and school improvement efforts, for example disciplinary policies that are therapeutic.
	Procedures for on-going assessment of student mental health and continuous improvement of school-based programs.
	Involvement of pupil services personnel, including credentialed school counselors, school psychologists, school social workers, speech-language therapists and audiologists, resource specialists, and school nurses where available, in the planning and executing of systems and policy changes.
	Meet current state curriculum mandates for health and wellness.
3.	Education and Training: School/district personnel should receive education and training to support the successful implementation of specific school-based programs as well as the systems and policy changes needed to sustain these programs.

4.	Technical Assistance: In order to support the effective development of comprehensive student mental health programs, the SMHI will include funding for technical assistance to support program development and implementation through the provision of resources on best practices, convening to exchange and share information and lessons learned, and access to on-site consultation to increase the effectiveness of SMHI-funded programs.
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Illustrative Themes:

- Outreach to the Latino communities
- A uniform approach across district and counties is recommended
- Develop formal partnerships between school systems, county mental health departments, students, families
- “Student Mental Health Policy Workgroup” includes, at a minimum, the Department of Mental Health, Department of Education, County Mental Health, school districts, mental health provider agencies, advocacy groups related to school health, children’s mental health, special education
- Mobilize resources to assist in developing curriculum
- Include consideration for youth that are blind/visually impaired
- Leverage Inspire’s existing mental health information and support Website for 16-24 year olds and others
- Think beyond traditional classroom, text book delivery formats—developing on-line education and training programs
- Efforts focused on the school climate, staff training, early identification
- Creating procedures for screening, for more engaged and persistent case management to follow up with those identified as needing care

Strategic Plans

SUICIDE PREVENTION

STRATEGIC DIRECTION 1:

Create a System of Suicide Prevention

Recommended Action(s) at the State Level	Submissions				
	State Org	County Org	Regional Org	Individual	Total
1.1 Establish an Office of Suicide Prevention to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices, and community planning.	1	0	0	0	1
1.2 Engage a coalition of public partners to integrate, coordinate, enhance, and improve policies and practices that prevent suicide. (list of partnerships)	4	5	0	0	9
1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. (list of partnerships)	5	2	0	0	7
1.4 Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.	3	0	0	0	3
1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level, and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.	1	3	0	0	4
1.6 Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.	2	5	0	0	7
1.7 Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness, and recovery.	0	1	0	0	1
Recommended Action(s) at the Local Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
1.8 In each county, appoint a liaison to the state Office of Suicide Prevention, and build upon an existing body or convene a new suicide prevention advisory council to collectively address local suicide prevention range of local stakeholders with expertise and experience with diverse at-risk groups. (list of inclusions)	1	1	0	0	2
1.9 Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the entity designated as the local suicide prevention advisory council.	2	2	0	1	5

1.10 Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide.	1	1	0	0	2
1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders, and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.	2	3	0	0	5
1.12 Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems.	2	2	0	0	4
1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.	5	2	0	0	7
1.14 Ensure that the county has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.	0	2	0	0	2
1.15 For counties with an established, accredited suicide prevention hotline call center, work with the Office for Suicide Prevention to explore opportunities to provide training and consultation to other counties to develop their suicide prevention hotline capacity.	0	1	0	0	1

STRATEGIC DIRECTION 2:

Implement Training and Workforce Enhancements to Prevent Suicide.

Recommended Action(s) at the State Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
2.1 Convene expert workgroups to recommend, develop, disseminate, broadly promote, and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.	8	8	0	0	16
2.2 Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, graduate <i>(sentence not complete in strategic plan)</i>	2	3	0	0	5
2.3 Following implementation of 2.1 and 2.2, develop and implement a process for determining within five years which occupations are to be targeted for required training and how the requirements will be implemented.	1	2	0	0	3

Recommended Action(s) at the Local Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
2.4 Establish annual targets for suicide prevention training that identify the number of individuals and occupations that will receive training, and the models, including peer support, which will be used for training. Using an inclusive process for input, develop, and implement training plans that meet these targets.	1	5	0	1	7
2.5 Increase the priority of suicide prevention training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs.	0	2	0	0	2

STRATEGIC DIRECTION 3:

Educate Communities to Take Action to Prevent Suicide.

Recommended Action(s) at the State Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
3.1 Launch and sustain a suicide prevention education campaign with messages that have been tested to be effective for diverse communities and that address warning signs, suicide risk and protective factors, and how to get help.	6	8	0	0	14
3.2 Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.	3	2	0	0	5
3.3 Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness, and mental health services that support suicide prevention efforts.	3	3	0	0	6
3.4 Promote information and resources about strategies that reduce access to lethal means, such as gun safety education and increasing compliance with existing gun safety laws, safe medication storage, and physical and non-physical deterrent systems on bridges or other high structures.	2	0	0	0	2
3.5 Disseminate and promote models for suicide prevention education for community gatekeepers.	7	2	0	0	9

Recommended Action(s) at the Local Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
3.6 Building grassroots outreach and engagement efforts to coordinate with and tailor the statewide suicide prevention education campaign and activities to best meet community needs.	1	3	0	0	4
3.7 Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.	0	2	0	0	2

3.8 Educate family members, caregivers, and friends of those who have attempted suicide, individuals who have attempted suicide, and community helpers to recognize, appropriately respond to, and refer people demonstrating acute warning signs.	3	5	0	0	8
3.9 Promote and provide suicide prevention education for community gatekeepers.	3	5	0	0	8
3.10 Develop and disseminate directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.	2	4	0	0	6
3.11 Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.	3	3	0	1	7

STRATEGIC DIRECTION 4:

Improve Suicide Prevention Program Effectiveness and System Accountability.

Recommended Action(s) at the State Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
4.1 Develop a California surveillance and research agenda on suicide, suicide attempts, and suicide prevention to support data-driven policies and evidence-based programs.	2	1	0	0	3
4.2 Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.	5	1	0	0	6
4.3 Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.	4	3	0	0	7
4.4 Coordinate with the Office of Suicide Prevention and county suicide prevention liaisons to make data and reports more accessible to, and in more user-friendly formats for, the public at large and policy makers at all levels to improve understanding of suicide and suicide attempts and to enhance prevention efforts for all population groups.	2	3	0	0	5
Recommended Action(s) at the Local Level:	Submissions				
	State Org	County Org	Regional Org	Individual	Total
4.5 Increase local capacity for data collection, reporting, surveillance, and dissemination to inform prevention and early intervention program development and training.	0	1	0	1	2
4.6 Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.	0	2	0	0	2

4.7 Establish or enhance capacity for a clinical and forensic review of suicide deaths in each county. The suicide death review process should include reporting de-identified data and findings to the State Office of Suicide Prevention and the local suicide prevention advisory council at minimum. The advisory council could use the reports to inform local policy action recommendations. Members of the case review teams should include representative of the Office of the Coroner/Medical Examiner and as appropriate other officials with legal access to confidential information.	1	1	0	0	2
4.8 Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.	0	0	0	0	0

STIGMA AND DISCRIMINATION REDUCTION

(\$60 million, \$15 million p/FY for four years)

STRATEGIC DIRECTION 1:

Creating a supportive environment for all consumers and those at risk for mental health challenges, family members, and the community at large establishing social norms that recognize mental health is integral to everyone's well-being.

Recommended Action(s)	Submissions				
	State Org	County Org	Regional Org	Individual	Total
1.1 Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis; and persons living with mental health challenges have resilience and the capacity for recovery.	5	3	1	0	9
1.2 Prevent the development of mental health stigma, stereotyping, and discrimination.	1	0	0	0	1
1.3 Create opportunities and forums for strengthening relationships and understanding between consumers, family members, and the larger community.	3	1	0	1	5
1.4 Reduce self-stigma of individuals living with mental health challenges and stigma by association for their family members.	4	4	0	0	8
1.5 Recognize peer-run and peer-led programs as an important means for reducing stigma.	6	2	0	1	9
1.6 Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.	6	4	1	0	11
1.7 Provide increased support for those closely involved with the lives of individuals facing mental health challenges.	6	2	1	0	9

<i>1.8 Reduce the effects of stigma with a strength-based approach to assessment, diagnosis, treatment planning, and interventions.</i>	6	6	0	0	12
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STRATEGIC DIRECTION 2:

Promoting awareness, accountability, and changes in values, practices, policies, and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges.

Recommended Action(s)	Submissions				
	State Org	County Org	Regional Org	Individual	Total
<i>2.1 Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices, and policies.</i>	4	3	0	0	7
<i>2.2 Establish developmentally appropriate prevention, recovery, and wellness programs.</i>	3	3	0	0	6
<i>2.3 Ensure that mental health services are offered in non-traditional, non-stigmatizing community and school sites.</i>	7	3	0	0	10
<i>2.4 Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care, and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.</i>	6	6	1	1	14
<i>2.5 Promote the dignity and safety of mental health consumers and their family members by training and educating law enforcement, first responders, other medical personnel, and the community at large to reduce stigmatizing attitudes and discriminating behavior. Educate the public about community resources available to assist with mental health-related crises; utilize informed consent as a means to ensure voluntary choice; prepare and equip law enforcement to better respond to the needs of individuals in mental health-related crisis; and eliminate a perceived need for the use of force and forced compliancy through these and other systematic alternatives referred to earlier in this Plan.</i>	6	3	1	1	11
<i>2.6 Educate employers on the importance of mental health wellness for all employees.</i>	1	1	0	0	2
<i>2.7 Expand opportunities for employment, professional development, upward mobility, retention, and success of mental health consumers in public, nonprofit, and private sector workplaces by enforcing current laws and challenging hiring biases.</i>	2	3	0	1	6

2.8 Eliminate discriminatory barriers to better meet the housing needs of mental health consumers by: educating the general public, landlords, and local officials on the rights and housing needs of mental health consumers and their families/caretakers; ensuring that all private and subsidized housing meets the nondiscrimination requirements of the Fair Housing Act and that their admissions procedures and management practices ensure all applicants and tenants have equal opportunities to benefit from the housing; encouraging supportive housing and other housing for individuals with disabilities to be well integrated throughout the community, accommodating of all levels of care; promoting the provision of housing first as one means to eliminating discriminatory barriers; and promoting the accessibility of services in housing.	1	0	1	2	4
2.9 Engage and educate the commercial, ethnic, public/community, and interactive media, as well as the entertainment industry, on standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and ways to serve as a resource for communicating accurate and non-stigmatizing information to the public on mental health issues and community resources.	3	2	1	0	6
2.10 Promote and enhance initiatives, programs, and curricula to change school cultures and increase social inclusion and social acceptance.	5	5	0	0	10

STRATEGIC DIRECTION 3:

Upholding and advancing federal and state laws to identify and eliminate discriminatory policies and practices.

Recommended Action(s)	Submissions				
	State Org	County Org	Regional Org	Individual	Total
3.1 Increase awareness and understanding of existing laws and regulations that protect individuals living with mental health challenges and their family members against discrimination.	1	2	0	1	4
3.2 Promote the compliance and enforcement of current anti-discrimination laws and regulations.	2	2	0	1	5
3.3 Work to enhance and/or amend current statutes and regulations to further protect individuals and their family members from discrimination.	2	0	0	0	2
3.4 Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.	1	3	0	1	5

STRATEGIC DIRECTION 4:

Increasing knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

<u>Recommended Action(s)</u>	Submissions				
	<i>State Org</i>	<i>County Org</i>	<i>Regional Org</i>	<i>Individual</i>	<i>Total</i>
<i>4.1 Develop and implement a plan to address the information gaps on how to reduce stigma and discrimination to build effective and promising anti-stigma and anti-discrimination programs.</i>	3	4	0	1	8
<i>4.2 Increase the skills and abilities of community participants to evaluate programs.</i>	1	3	0	1	5
<i>4.3 Ensure that research and evaluation projects adapt and respond to community needs.</i>	2	2	0	1	5
<i>4.4 Disseminate the lessons learned, promising practices, and other outcome findings.</i>	2	3	0	1	6

STUDENT MENTAL HEALTH

(\$60 million, \$15 million p/FY for four years)

STRATEGIC DIRECTION 1: HIGHER EDUCATION

Design and administer programs that will focus on three key strategic directions—training, peer support activities and suicide prevention—that can be implemented at any college, district, multi-campus collaborative, or system within one of the three California public higher education systems.

<u>Recommended Action(s)</u>	Submissions				
	<i>State Org</i>	<i>County Org</i>	<i>Regional Org</i>	<i>Individual</i>	<i>Total</i>
<i>1. Training: The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness, and to promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community.</i>	2	4	0	0	6

<p>2. <i>Peer-to-Peer Support: These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.</i></p>	4	4	0	1	9
<p>3. <i>Suicide Prevention: These programs would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students, and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.</i></p>	3	3	0	1	7

STRATEGIC DIRECTION 1: K-12

Design and administer programs that will focus on three key strategic directions—training, peer support activities and suicide prevention—that can be implemented at any college, district, multi-campus collaborative, or system within one of the three California public higher education systems. Four strategic directions should be incorporated into a comprehensive student mental health program funded by the SMHI.

Recommended Action(s)	Submissions				
	State Org	County Org	School District	Individual	Total
<p>1. <i>School-Based Programs: Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including:</i></p> <ul style="list-style-type: none"> • <i>Efforts that foster supportive school climates including bullying prevention, suicide prevention, stigma reduction, and cultural awareness.</i> • <i>Mental health educational programs for students that include a focus on stigma reduction, incorporate age-appropriate suicide prevention training for the general student population, and are in alignment with state Health Education Standards.</i> • <i>Early identification of students with mental health concerns who seek help, including universal voluntary screenings in partnership with families and caregivers.</i> • <i>Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs, and community-based organizations.</i> • <i>Outreach and education for families that are culturally and linguistically responsive and reduce the stigma associated with accessing and using mental health services.</i> 	9	10	1	1	21

<ul style="list-style-type: none"> • <i>Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for specific mental health needs, for example suicide risk among African-American and Caucasian males, Asian-American females, Hispanic males and females, LGBTQ youth and Native American youth.</i> • <i>Training for those personnel, like teachers, most likely to first identify potential mental health needs, which includes resources for identification, referral, and non-stigmatizing responses.</i> • <i>Use of appropriate youth peer-to-peer strategies.</i> 					
2. Systems and Policy Developments: Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include:	4	7	0	2	13
<ul style="list-style-type: none"> • <i>Coordination and redirection of resources through school, district-wide, regional and/or statewide systems to create a cohesive and comprehensive system from prevention and early intervention to intervention and support for student mental health as opposed to fragmented programs.</i> • <i>Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.</i> • <i>Collaboration with community-based providers that enhance student success, for example health services, tutoring, after-school programs, or mentoring.</i> • <i>Development of policies within the school/district/region/state that make mental health promotion an integral part of school operations and school improvement efforts, for example disciplinary policies that are therapeutic.</i> • <i>Procedures for on-going assessment of student mental health and continuous improvement of school-based programs.</i> • <i>Involvement of pupil services personnel, including credentialed school counselors, school psychologists, school social workers, speech-language therapists and audiologists, resource specialists, and school nurses where available, in the planning and executing of systems and policy changes.</i> • <i>Meet current state curriculum mandates for health and wellness.</i> 					
3. Education and Training: School/district personnel should receive education and training to support the successful implementation of specific school-based programs as well as the systems and policy changes needed to sustain these programs.	7	6	0	1	14

<p>4. Technical Assistance: <i>In order to support the effective development of comprehensive student mental health programs, the SMHI will include funding for technical assistance to support program development and implementation through the provision of resources on best practices, convening to exchange and share information and lessons learned, and access to on-site consultation to increase the effectiveness of SMHI-funded programs.</i></p>	7	6	0	0	13
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Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Alexander Fajardo	✓		✓	Priorities, comments	Individual	Individual	Individual
Amber Burkan, Director California Youth Empowerment Network (CAYEN)	✓	✓	✓	Priorities, comments	State-wide	Non-profit	Transition Age Youth
Becky Perelli, RN, MS Health Services Association, California Community Colleges		✓		Comments	State-wide	Association	Community College Students
Benita Ramsey San Bernardino Department of Mental Health			✓	Comments	San Bernardino County	County	San Bernardino County
Beth Sise Scripps Mercy Hospital			✓	Priorities	San Diego County	Hospital	Health Services
Betsy Gowan Butte County Department of Behavioral Health	✓	✓	✓	Priorities, comments	Butte County	County	Butte County
Betsy Sheldon California Community Colleges Chancellor's Office	✓	✓	✓	Priorities, comments	State-wide	Community College	Community Colleges
Catherine A. Huerta Fresno County Department of Social Services	✓	✓	✓	Priorities	Fresno County	County	Fresno County

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Cathy Spensley, MSW Family Service Agency of San Francisco	✓		✓	Priorities, comments	San Francisco County	Agency	Family services
Christa Thompson Calaveras County Behavioral Health Services	✓			Comments	Calaveras County	County	Calaveras County
Christin Hemann Aging Services of California	✓		✓	Priorities, comments	State-wide	Non-profit	Older Adults
David Kopperud California Association of Supervisors of Child Welfare and Attendance		✓		Priorities	State-wide	Association	K-12
David N. Thorne	✓	✓	✓	Comments	Fresno County	Individual	Adult Consumer
Delphine Brody California Network of Mental Health Clients	✓	✓	✓	Priorities, comments	State-wide	Network	Mental Health Consumers
Diane A. Suffridge, PhD Family Service Agency of Marin		✓		Priorities, comments	Marin County	Agency	Families
Donna Peterson San Diego Coalition for Mental Health	✓			Priorities, Comments	San Diego County	Coalition	San Diego County
Erick		✓	✓	Comments	Individual	Individual	Individual
Felix A. Bedolla Napa County Health and Human Services	✓	✓	✓	Comments	Napa County	County	Napa County

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Fran Edelstein California Alliance of Child and Family Services	✓	✓	✓	Priorities, comments	State-wide	Association	K-12, Family Services
James L. Davis, Chair California Commission on Aging	✓		✓	Priorities, comments	State-wide	Commission	Older Adults
Jay Allen, Executive Vice President & COO Junior Blind of America	✓	✓	✓	Comments	State-wide	Non-profit	Visually impaired
Jeannie Morris Napa County Office of Education		✓		Priorities, comments	Napa County	County	Napa County, K-12
John Bateson, Co-chair Contra Costa County Suicide Prevention Committee			✓	Comments	Contra Costa County	Committee	Contra Costa County
John Bateson, Executive Director Contra Costa Crisis Center			✓	Comments	Contra Costa County	Non-profit	Community
Jonathan Buffong	✓			Priorities, comments	Individual	Individual	Individual
Jose J. Aguirre	✓	✓		Priorities, comments	Individual	Individual	Individual
Karen George Sacramento County Office of Education – Project TEACH	✓	✓	✓	Priorities, comments	Sacramento County	County	K-12

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Karen Hurley Stanislaus County Behavioral Health and Recovery Services	✓	✓	✓	Priorities	Stanislaus County	County	Stanislaus County
Karen Pugh Montebello Unified School District		✓		Priorities	Montebello Unified School District	School District	k-12
Kathi Anderson, Executive Director Survivors of Torture, International	✓	✓	✓	Priorities, comments	State-wide	Non-profit	Survivors of government-sanctioned torture abroad
Kathleen Casela-Young (Adult Advocate) Mental Health Association of San Francisco	✓	✓	✓	Priorities, Comments	San Francisco	Association	Mental Health Consumers
Kathleen Derby NAMI California	✓	✓	✓	Priorities, comments	State-wide	Organization	Mental Health Consumers
Keith Edward Torkelson, MS, BS, PpMHW MSG in Orange County	✓			Priorities, comments	Orange County	Individual	Orange County
Khatera Aslami Peers Envisioning and Engaging in Recovery Services	✓			Priorities, comments	Alameda County	Non-profit	Alameda County
Kristen Gardner Marin County CMH-MHSA PEI	✓		✓	Priorities	Marin County	County	Marin County
Leslie Lessenger, PhD Napa-Solano Psychological Association			✓	Priorities, comments	Napa County Solano County	Association	Napa and Solano Counties

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Lin Benjamin, MSW, MHA California Department of Aging	✓		✓	Priorities, comments	State-wide	State	Older Adults
Lisa Nerenberg California Elder Justice Workgroup	✓		✓	Priorities, Comments	State-wide	Workgroup	Older Adults
Luther Hert Monterey County Mental Health Commission – Member	✓	✓	✓	Comments	Monterey County	Individual	Monterey County
M. Gutierrez		✓		Priority, comments	Individual	Individual	Individual
Margaret Hallett, Executive Director Family Service Agency of Marin			✓	Priorities, comments	Marin County	Agency	Families
Marilyn Hein San Jacinto Unified School District			✓	Comments	San Jacinto Unified School District	School District	K-12
Michelle Callejas, MFT Sacramento County Department of Behavioral Health Services	✓	✓	✓	Priorities	Sacramento County	County	Sacramento County
Monica Nepomuceno California Department of Education	✓	✓	✓	Priorities	State-wide	State	K-12
Nancy A. Salamy, MFT, Executive Director Crisis Support Services of Alameda County			✓	Priorities, comments	Alameda County	Suicide Hotline	Suicide Prevention

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Nazia Ali The Child Abuse Prevention Council of Sacramento, Inc		✓	✓	Priorities, comments	Sacramento County	Council	Sacramento County
Patrick Arbore, EdD Center for Elderly Suicide Prevention and Grief Related Services, Institute on Aging	✓		✓	Priorities, comments	San Francisco		Older Adults
Patsy Hampton WestEd Center for Prevention and Early Intervention	✓			Priorities, Comments	Sacramento	Center	Children and Adolescents
Ramona Davies Northern California Presbyterian Homes and Services	✓		✓	Priorities, comments	Marin County Mendocino County Plumas County San Francisco County	Non-profit	Older Adults
Raul R. Sanchez	✓	✓	✓	Priorities	Individual	Individual	Individual
Russell B Vergara Multi-Ethnic Collaborative of Community Agencies	✓			Priorities, Comments	State-wide	Agency	
S. Todd Stolp, M.D. Tuolumne County Health Department	✓	✓	✓	Priorities	Tuolumne County	County	Tuolumne County
Sanjuana M. Ramos			✓	Comments	Individual	Individual	Individual
Serena Clayton, PhD, Executive Director California School Health Centers Association		✓		Priorities, comments	State-wide	Association	K-12

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Sergio Aguilar-Gaxiola The California Latino Mental Health Concilio	✓	✓	✓	Priorities	State-wide	Council	Latino Mental Health
Solano County MHSA Stakeholders	✓	✓	✓	Priorities, comments	Solano County	Individuals, organizations	Solano County
Stacie Hiramoto Racial and Ethnic Mental Health Disparities (REMHDCO)	✓	✓	✓	Priorities, comments	State-wide	Coalition	Racial & Ethnic Mental Health Consumers
Stephanie Welch, MSW California Mental Health Directors Association (CMHDA)	✓	✓	✓	Comments	State-wide	Association	Mental Health Services
Stewart Teal, M.D., President The California Academy of Child and Adolescent Psychiatry (Cal-ACAP)	✓	✓	✓	Priorities, comments	State-wide	Academy	Child and Adolescent Psychiatry
Sue Shrader-Hanes, MFT Mesa College Student Health Services	✓	✓	✓	Comments	Mesa College, San Diego	Community College	Community Colleges
Susan G. Keys, PhD Inspire USA Foundation		✓	✓	Priorities, comments	State-wide	Non-profit	Teens and young adults
Terri Restelli-Deits Area Agency on Aging Serving Napa and Solano	✓		✓	Priorities, Comments	Napa & Solano Counties	Agency	Older Adults
Unknown Individual	✓	✓	✓	Comments	Individual	Individual	Individual

Stakeholder	Strategic Plans Submitted On			Priorities and/or Comments Submitted	Geographic Scope	Entity	Focus
	Stigma & Discrimination Reduction	Student Mental Health	Suicide Prevention				
Viviana Criado California Elder Mental Health and Aging Coalition	✓		✓	Comments	State-wide	Coalition	Older Adults
Wesley K. Mukoyama, LCSW, Chairperson Older Adults Committee, Santa Clara County Mental Health Board			✓	Priorities, comments	Santa Clara County	County	Older Adults

California Strategic Plan on Suicide Prevention

Submission Themes	Submissions				
	State Org	County Org	Regional Org	Individual	Total
Family/Client Education	1	0	0	0	1
Depression Care Delivery	1	0	0	0	1
Community Education	0	0	0	2	2
Peer-to-Peer Guidance and Education	1	3	0	0	4
Firearm education	0	0	0	1	1
Marketing targeted at youth	3	0	0	0	3
Marketing targeted at older adults	1	0	0	0	1
Professional Education	1	0	0	0	1
Professional Education re individuals with disabilities	1	0	0	0	1

California Strategic Plan on Stigma and Discrimination Reduction

Submission Themes	Submissions				
	State Org	County Org	Regional Org	Individual	Total
Primary care community education	1	1	0	1	3
Peer-to-peer guidance and education	2	0	0	0	2
Family/community education	3	0	0	1	4
Cultural, linguistic services and dissemination of education	3	2	1	2	8
Education for criminal justice, legal, education professionals	2	0	0	0	2
Services targeting older adults	1	0	1	0	2
Overall psychiatric medication and counseling availability at all higher education campuses	1	1	0	0	2
Anonymity of visits to student health centers	0	1	0	0	1

California Strategic Plan on Student Mental Health

Submission Themes	Submissions				Total
	State Org	County Org	Regional Org	Individual	
Community, school and family education	3	2	0	0	5
Leveraging	1	2	0	0	3
Federal reimbursement in the health system	1	0	0	0	1
Training	2	1	0	0	3
Holistic approach to managing mental health	1	0	0	0	1
Release time follow-up	1	0	0	0	1
Cultural outreach	1	0	0	1	2
On-line and Web-based outreach, education	2	0	0	0	2
Coordinating previously existing programs with new programs	3	0	0	0	3
Peer-to-peer guidance and education	6	0	0	0	6
Screening	2	0	0	0	2
Social norming	1	1	0	0	2

ADMINISTRATIVE MATTERS

Agenda Item 8.A.

SUBJECT: CalMHSA Bylaws

BACKGROUND AND STATUS:

CalMHSA last revised and approved its Bylaws at the July 15, 2010 board meeting, since then another matter was brought forward that the Bylaws do not expressly acknowledge the weighted voting provisions of the Joint Exercise of Powers Agreement. Staff proposes that Article 4, Section 4.3 of the Bylaws be amended to incorporate the weighted voting procedure, as follows:

Amendment Language:

All matters within the purview of the Board may be decided by a majority vote of the Board, except as to matters which are specified in Section 4.1.3 as requiring a super majority vote of the Board. However, upon the motion of any Board Member, seconded by another, passage of a measure by the Board will require approval through a weighted voting procedure rather than by majority or super majority vote. For weighted voting purposes there shall be a total of 75 votes. Each Member shall have one vote. The remaining votes shall be allocated among the Members based on the most recent census. This calculation shall be performed and reviewed annually in June, prior to the next fiscal year. Any weighted vote will be a roll call vote. Weighted votes must be cast in whole by the voting county and may not be split.

Current Bylaw Language:

All matters within the purview of the Board may be decided by a majority vote of the Board, except for as those matters which are specified as requiring a super majority vote of the Board, which then must be decided by the vote specifically prescribed in Section 4.1.3.

RECOMMENDATIONS:

Staff recommends that the Board approve the proposed amendment of the Bylaws.

REFERENCE MATERIALS ATTACHED:

- CalMHSA Bylaws

**BYLAWS
of the
CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY**

ARTICLE 1

Section 1.1 - Purpose

The CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (Authority) is established for the purpose of the Members to jointly develop, and fund mental health services and education Programs as determined on a regional, statewide, or other basis. Such Programs may include, but are not limited to the following:

- (a) Addressing suicide prevention.
- (b) Ethnic and cultural outreach.
- (c) Stigma and discrimination related to mental illness.
- (d) Student mental health and workforce training and education.
- (e) The provision of necessary administrative services. Such administrative services may include, but shall not be limited to, establishing a depository for research materials and information regarding “best practices.”

ARTICLE 2 - GOVERNING DOCUMENTS

Section 2.1 - Governing Documents

The governing documents of the Authority shall be the Joint Powers Agreement of the Authority (Agreement), these Bylaws, and the Participation Agreement for each Program developed.

ARTICLE 3 - MEMBER ENTITIES

Section 3.1 - Membership

Each party to the Agreement is a Member. Only those agencies defined in the Joint Powers Agreement are eligible to become a Member of the Authority by agreeing to be bound by the governing documents and by complying with all of the following requirements:

- 3.1.1 Submit a completed application for membership and indicate method for payment of Application Fee..
- 3.1.2 Submit copy of resolution providing ~~authoriation~~authorization to join CalMHSA;
- 3.1.3 Execute the Joint Powers Agreement ;
- 3.1.4 Be accepted for membership as provided in Section 3.2;
- 3.1.5 Identify in writing a director to represent the Member on the Board. The director will designate an alternate to the Board as provided in Article 4;

- 4.1.3.9 Expel a member from the Authority (two-thirds vote of the entire Board);
- 4.1.3.10 Terminate or suspend the rights of a member in default (two-thirds vote of the entire Board); and
- 4.1.3.11 Approve dissolution of Authority (two-thirds vote of entire Board.)

Section 4.2 - Meetings of the Board

- 4.2.1 The Board shall hold at least two regular meetings each year to review all operations of the Authority. The Board will establish a time and place to hold such regular meetings and notice shall be sent to each director, alternate. The Authority Secretary shall be responsible for minutes of the meetings, submission of copies of such minutes to the directors, and alternate representatives.
- 4.2.2 Every Member is expected to have its director or alternate attend Board meetings.
- 4.2.3 All meetings of the Board shall be conducted in accordance with the Ralph M. Brown Act (Government Code §54950 et seq.)
- 4.2.4 A special meeting may be called by the President or Vice President in the absence of the President, or a majority of the Board, by notifying the Executive Director of the purpose of the meeting. The Executive Director shall provide 24 hours written notice to each director and alternate representative stating the purpose, date, time, and place of the meeting.

Section 4.3 - Voting

All matters within the purview of the Board may be decided by a majority vote of the Board, except ~~for~~ as to those matters which are specified in Section 4.1.3 as requiring a super majority vote of the Board, ~~which then must be decided by the vote specifically prescribed in Section 4.1.3. However, upon the motion of any Board Member, seconded by another, passage of a measure by the Board will require approval through a weighted voting procedure rather than by majority or super majority vote. For weighted voting purposes there shall be a total of 75 votes. Each Member shall have one vote. The remaining votes shall be allocated among the Members based on the most recent census. This calculation shall be performed and reviewed annually in June, prior to the next fiscal year. Any weighted vote will be a roll call vote. Weighted votes must be cast in whole by the voting county and may not be split.~~

ARTICLE 5 – OFFICERS OF THE BOARD

Section 5.1 - Officers

The Officers of the Authority shall consist of President, Vice President, Treasurer, and a Secretary to the Board.

Section 5.2 - Eligibility for President, Vice President, Treasurer and Secretary

Eligibility for election and continuation in office as President, Vice President, Treasurer and Secretary of the Board shall be limited to one representative of a Member.

ADMINISTRATIVE MATTERS

Agenda Item 8.B.

SUBJECT: Draft Purchasing and Procurement Policy

BACKGROUND AND STATUS:

At the previous board meeting staff brought forward the CalMHSA procurement policy along with a sample of Monterey's First 5 procurement policy for recommendations on how to improve the current policy. It was discussed that current policy may need to be expanded due to the anticipated need for plan execution.

CalMHSA has now developed a revised draft procurement policy which is important to have in place as we enter the planning stages of the three statewide programs. The policy reflects some elements of the Monterey First 5 procurement policy and other revisions.

In addition, a Conflict of Interest Policy and Non-Conflict Statement have been drafted to coincide with the Draft Purchasing and Procurement Policy.

In order to execute an RFP it is critical to have procurement and conflict of interest policies in place, as such, review and guidance of the draft documents is requested.

RECOMMENDATION:

For discussion and/or action should action be deemed appropriate.

REFERENCE MATERIALS ATTACHED:

- Draft Purchasing and Procurement Policy
- Draft Conflict of Interest Policy
- Draft Non-Conflict Statement

CalMHSA PURCHASING AND PROCUREMENT POLICY

SECTION 1: PURPOSE

The purpose of this purchasing policy is to provide a framework describing the different methodologies used to procure goods and services. The methodologies described below are intended to insure fairness and accountability in the selection process while affording the flexibility necessary to efficiently conduct the business affairs of CalMHSA.

SECTION 2: POLICY

California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) of county (and in some cases, city) mental health programs (Counties) acting jointly. Among other things, CalMHSA implements Prevention and Early Intervention (PEI) Statewide Programs under a contract with the California Department of Mental Health (DMH) pursuant to Welfare and Institutions Code (WIC) section 5897(a) subject to review and/or approval by the Mental Health Services Oversight and Accountability Commission (OAC) as required by the Mental Health Services act (Act). Under its Joint Exercise of Powers Agreement, CalMHSA has the power to enter into contracts necessary or appropriate to carry out the provisions of the Act. No individual may contract on behalf of CalMHSA unless he or she has been specifically delegated authority by this policy or other act of the CalMHSA Board of Directors.

Contracts must be consistent with the Program and Expenditure Plan, update, and/or work plan approved by DMH and/or OAC as required (Program plan). All contracts will include this requirement and will be monitored to assure consistency with the approved Program plan. Consistent with the requirements of the Act, performance will be evaluated by measurable client outcomes. Such evaluation will be a part of every contract.

CalMHSA is not required to award a contract for services to the proposal with the lowest cost. CalMHSA will select the service provider that best meets the needs of the Program.

SECTION 3: PURCHASE OF GOODS

Section 3.1: General Rules

Procurement of goods by CalMHSA must be approved by the Board, or by **Committee of the Board** to whom such authority is delegated.

The purchase of goods with the unit cost of less than \$25,000 for the same or similar goods from the same vendor in the same fiscal year may be procured using an informal selection process as described in Section 5.

The purchase of goods over \$25,000 for the same or similar goods from the same vendor in the same fiscal year requires an Invitation to Bid (ITB) as described in Section 7 or a similar process. Incremental contracting with the same vendor cannot be used to avoid the requirements of this policy.

Section 3.2: Preference For Recycled Products

1. Recycled products will be purchased whenever they are available at the same or lesser total cost than non-recycled items. A preference may be given to a vendor of recycled products in accordance with Public Contract Code sections 22150(b) and (c).
2. All vendors must certify in writing the minimum, if not exact, percentage of postconsumer materials in products offered or sold to CalMHSAs.
3. Vendors must certify in writing if printer or duplication cartridges comply with Public Contract Code section 12156, which prohibits restrictions on recycling or remanufacturing of such cartridges unless the vendor has a recycling or remanufacture program.
4. The written certification requirement in 2, and 3, above may be waived if the percentage of post consumer materials in the goods can be verified in product written materials.
5. All printing contracts must provide that the paper used meets the recycled contract requirements of Public Contract Code section 12209, which requires recycled printing and writing paper to consist of at least 30%, by fiber weight, post-consumer fiber.

SECTION 4: PURCHASE OF SERVICES

Procurement of services by CalMHSAs must be approved by the Board, or by a Committee of the Board to whom such authority is delegated; provided, however, that any contract for administrative or legal services shall be approved by the full Board.

The purchase of services less than \$25,000 for the same or similar services from the same vendor in the same fiscal year may be procured by using an informal selection process as described in Section 5.

The purchase of services over \$ 25,000 for the same or similar services from the same vendor in the same fiscal year requires a Request for Proposals process unless the Selection Process Exceptions in Section 8 apply.

The Board has the authority to extend a contract in order to enable the contractor to complete the Scope of Work as long as there are no additional costs incurred.

Incremental contracting with the same vendor cannot be used to avoid the requirements of this policy.

SECTION 5: INFORMAL SELECTION PROCESS

No documented process is required for purchases of the same or similar goods or services from a single vendor in the same fiscal year if the total purchase price does not exceed \$5,000.

For purchases of the same goods or services from a single vendor in the same fiscal year above \$5,000 but less than \$25,000, an Informal Selection Process involves a price request over the phone, fax or email from at least three vendors and selecting the vendor that best fits CalMHSA's needs, considering quality and price. The request and any responses must be documented. If it is not possible to obtain at least three offers, the reasons should be documented in writing. A written record must be created for phone solicitations. An Informal Selection Process may be used only if the goods or services are clearly defined and a potential vendor can give an accurate price quotation. If the goods or services are not so clearly defined, the procedures in Sections 6 or 7 should be used instead.

Upon successful completion of the initial term, contracts for services procured through an informal selection process may be extended for up to an additional year if it is in CalMHSA's best interest to do so.

For purchases of goods or services from a single vendor in the same fiscal year above \$25,000, the procedures in Sections 6 and 7 apply.

SECTION 6: REQUEST FOR PROPOSALS (RFP)

A Request for Proposal (RFP) is used for solicitation purposes when CalMHSA's requirements are not well defined but CalMHSA needs to achieve specified outcomes. The solicitation requires the potential vendor to prepare a written proposal that explains in detail how the potential vendor plans to meet CalMHSA's requirements. Innovative ideas and techniques that may benefit CalMHSA may be included in the proposal.

An RFP award is not made based on the lowest price, but upon technical superiority of the proposal within a reasonable proximity to the other proposed prices. The initial term and provisions for allowable extensions will be specified in the RFP.

The full possible contract term includes the initial term and any allowable extensions as specified in the RFP. After the full possible contract term, the contract may be extended or a new contract may be executed with the same vendor for the same or similar services for one additional year without conducting a new selection process if the vendor is meeting the service delivery goals and it is in CalMHSA's best interest to continue the contract.

After the additional year of the contract, CalMHSA will evaluate the service delivery and determine whether to conduct a new selection process or if it is in CalMHSA's best interest to continue the contract for one more year.

A new selection process must be conducted after the extensions provided above.

An RFP should contain the following:

1. A brief description of CalMHSA and its purpose.
2. A description of the overall program of which the RFP is a part.
3. A clear and concise Requirements Statement describing the problem to be solved and what the Proposer is expected to accomplish. The requirements statement may include standards for quality and quantity, expected deliverables and time lines, outcome evaluation, eligibility requirements, staffing requirements, or financial requirements. The specifications contained in the requirements statement shall be nonrestrictive to provide an equal basis for competition and participation and an optimum number of potential vendors.
4. A statement of the budget for the service to be provided, or price limitations if there is not a specified budget amount. The budget or price description will describe the payment provisions under the contemplated contract, including a percentage limit on administrative costs, an absolute prohibition of payment beyond the contract price, and notice of any applicable holdback pending distributions of funds by DMH or other funding source in that such entities may have a policy of holding their final distribution until they receive completed fiscal and programmatic reports.
5. Proposer responsibility criteria that may include references, financial statements, licenses, bonding and insurance.
6. A sample of the contract the successful proposer will be expected to sign. The contract will incorporate provisions required by statute, by DMH and/or the OAC, and by CalMHSA. The RFP shall include a statement that by submitting a proposal, the Proposer has no objection to the attached draft or any of its provisions such that, if selected, the Proposer will enter into a final agreement based upon the sample contract.
7. Submission criteria including a calendar of key dates and times, instructions where and to whom proposals are to be submitted, and any formatting requirements.
8. A description of the review process and criteria for evaluating the proposal. The RFP shall set forth the criteria and may include the weight each is given. An oral interview may be included as part of the review process. Selection shall be based on the proposal most advantageous to CalMHSA based on the findings of the review panel.
9. Terms and conditions of the RFP process including, but not limited to CalMHSA's right to reject all proposals, amend, or cancel the RFP at any time for any reason before the contract is executed, to accept all or a portion of any proposal, and to waive any minor irregularities or informalities in any proposal, and to request clarification from any proposer.
10. A stated appeals process outlining the time, place and person to whom an appeal must be filed.
11. A contact person at CalMHSA who is available during the RFP process.

12. A statement that all proposals shall be treated as confidential until the selection process is completed, but thereafter all proposals will be deemed public records.

Proposals must be received at the time and place specified in the RFP solicitation. Late proposals cannot be accepted. Proposals remain confidential until a contract is executed.

A potential proposer may not be involved in drafting the RFP. While specifications can be obtained from potential service providers, CalMHSA is responsible for ensuring that those specifications are not unduly restrictive.

An RFP may be amended if the change is issued in writing in the form of an Addendum to all vendors who received the original solicitation and advertised in a manner consistent with the original RFP.

Review Panel

The Board/Committee/Staff/the Executive Committee/other appoints members of the review panel based on their qualifications and expertise. All review panel members must sign a Non-Conflict Statement. Review panel deliberations are confidential. CalMHSA staff and Board Members are not eligible to be scoring members on a review panel.

Review Panel Recommendation to Board for Approval

The review panel evaluates the proposal and recommends the proposal to the board for approval. The Board then determines whether to accept the proposal, or some part thereof, or restart the process.

Should it become apparent that a Request for Applications or Request for Qualifications process would be suitable, the board may adopt procedures consistent in spirit with this Policy.

SECTION 7: INVITATION TO BID (ITB)

An Invitation to Bid (ITB) is used to obtain clearly specified goods in excess of \$25,000 from the same vendor in the same fiscal year. The initial term and provisions for allowable extensions will be specified in the ITB. After the initial term, CalMHSA may extend or enter into a new contract with the same vendor for the same or similar goods without conducting a new selection process if the vendor is meeting the service delivery goals. After the second term or the contract, CalMHSA will review the contract and determine whether or not a new selection process is needed or if it is in CalMHSA's best interest to continue the contract.

All ITBs shall include the following:

1. A clear and concise specification that describes the goods sought, but it must not be too restrictive. For instance, if the specification requires "brand name or

equal,” the bidder offering “equal” must submit complete specifications and/or samplers with their bids. Determination of equity is the sole discretion of CalMHSA.

2. The bidder’s responsibility criteria that may include references, plan capacity, credit data, financial statements, licenses, bonding and insurance.
3. Submission criteria that may include a calendar of key dates and times, instructions where and to whom bids are to be submitted, the number of bids to be submitted, cost/pricing instructions, signature requirements and contact information.
4. Terms and conditions that will be incorporated into the purchase order or contract including, but not limited to, CalMHSA’s right to reject all bids, amend, or cancel the ITB at any time for any reason before the contract is executed, to accept all or a portion of any bid, and to waive any minor irregularities or informalities in any bid and to request clarification from any bidder.

After the bids are opened, they are evaluated by the individual, committee or panel to whom the Board has delegated authority for that purpose. Bids are to be evaluated based on the requirements set forth in the ITB, which may include criteria to determine acceptability such as inspection, testing, quality, workmanship, delivery, or suitability for a particular purpose. The evaluation shall be based on the face value of the bid and shall consider the following cost factors: the total bid price including discounts, the unit or extended price and the administrative costs, hour rates for specified personnel, CalMHSA’s administrative costs, maintenance costs and warranty provisions, life cycle cost, repurchase value or residual value of goods after a specified number of years in cases where the residual value can be objectively ascertained, the cost and rate of consumables, freight shipping and handling, assembly and start up.

The evaluation shall also include consideration of the following responsibility and responsiveness factors: general reputation and experience of the bidder, the bidder’s ability to service CalMHSA, financial ability to meet the requirements, prior knowledge of and experience with the bidder based on past performance, nature and extent of company data furnished by bidder upon request, size and location of bidder’s warehouse, bidder’s ability to meet delivery and stocking requirements, bidder’s experience with commodities or systems, length of time the commodities or systems have been on the market, adherence to the requirements and condition of the ITB, quality and quantity of merchandise offered, compatibility with existing commodities or systems, overall completeness of the commodity line offered and delivery or completion date. After the panel evaluates the bids, the award shall be made to the lowest responsible responsive bidder that meets the ITB requirements.

SECTION 8: COMPETITIVE SELECTION PROCESS EXCEPTIONS

All goods or services over \$5,000 shall be procured by a competitive selection process unless the Board determines one of the circumstances below is satisfied. The selection process or the exception must be documented.

1. Sole Source. If the goods or services are a sole source a written justification is required, and the written justification must be distributed with the agenda materials in advance of the meeting at which the contract is approved. One or more of the following factors may justify use of a sole source contract.
 - a. The uniqueness of a vendor's capabilities or goods offered to meet the needs of CalMHSA as compared to other contractors.
 - b. There is only one viable provider of the required service in the geographic area.
 - c. The prior experience of the proposed vendor is vital to the goods or services.
 - d. The facilities, staff or equipment the proposed vendor has that are specialized and vital to the services required.
 - e. Whether the contractor has a substantial investment that would have to be duplicated at the expense of CalMHSA if another vendor provided services.
 - f. The vendor's ability to provide goods or services in the required time frame.
 - g. Retaining professional services, such as but not limited to, an attorney, auditor, manager or administrator, to maintain expertise, continuity, consistency and knowledge of CalMHSA.
 - h. After a solicitation of a number of sources, competition is determined to be inadequate.
 - i. Patent rights or copyrights or secret processes the contractor possesses, compatibility with existing CalMHSA goods.
 - j. Existing equipment maintenance programs or contracts.
 - k. All relevant providers of a particular service in the geographic area will receive funding.
 - l. CalMHSA is contemplating a Program unlike any previously conducted and therefore has insufficient information to develop an RFP process or identify potential competitive providers.
2. Emergency. When goods or services are necessary to further the purpose of the Act or for the protection of CalMHSA personnel or property and time is of the essence.
3. State, County, or Federal Vendor. CalMHSA may use a vendor under contract with the State, a County, or Federal vendor without a competitive selection process if the State, County or Federal contract was procured by a competitive selection and the vendor accepts the same terms of the contract.

CalMHSA

CONFLICT OF INTEREST POLICY

SECTION 1: PURPOSE

The purpose of this policy is to define a conflict of interest and to establish a procedure for recognizing and reporting conflict of interest issues.

SECTION 2: POLICY

CalMHSA promotes business practices that comply with conflict of interest and disclosure requirements, including but not limited to, the California Political Reform Act of 1974 and California Government Code sections 1090-1097 and 1125-1129. When a Board member, staff member, contractor or agent in a position to influence a decision or who has decision making power identifies a conflict of interest, that person must not participate in or give consideration to the matter from that point forward.

SECTION 3: DEFINITIONS

1. “Proposer” means a person or organization responding to a Request for Proposals by CalMHSA. It also includes a person or organization responding to a Request for Applications.
2. “Sub-Contractor” means a current sub-contractor of the Proposer, or a sub-contractor under a proposed agreement with the Proposer.
3. “Conflict of interest” A person is deemed to have a conflict of interest if he or she, or his or her spouse or dependent child, has an “economic interest” in or economic relationship with a Proposer or Sub-Contractor or if he or she has other involvement with a Proposer or Sub-Contractor that could be perceived to impair his or her objectivity. A conflict of interest exists when the person involved has the ability to make, participate in, or use his or her official position to influence a CalMHSA decision; and
 - a. It is foreseeable that the decision will have a material effect on the person’s “economic interest” which is distinguishable from its effect on the public generally, or
 - b. The person has or has had a relationship with a Proposer or Sub-Contractor, or has a close relationship with a person who has such a relationship, and the decision will affect the interests of the Proposer or Sub-Contractor.
4. “Influence or decision making power.” A person has decision making power when the person is a board member, committee member or review panelist with the power to recommend or approve a proposal. A person has influence when he or she discusses,

advises, or makes recommendations to a person with decision making power either directly or indirectly, that is, without significant intervening substantive review.

5. “Economic interest” means any fee, money, or financial gain, or benefit 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, and reportable sources of income of the person, the person’s spouse, the person’s dependent child, or other relative of the person who lives in the person’s household.

Government salaries, per diem expenses and reimbursement for travel from a nonprofit entity, are all specifically excluded from the definition of income under the Fair Political Practices Act. Salaries from a nonprofit agency are considered an “economic interest”.

A Government salary also does not constitute an interest in a contract (under Government Code section 1090) unless the contract directly involves the department of the entity that employs a person in a decision making position, in which case, the person discloses the interest on the record and does not participate in the decision.

SECTION 4: PROHIBITION

A person with influence or decision making power at CalMHSA is prohibited from:

1. Serving on a review panel that evaluates a proposal or application by a Proposer as to whom the person has a conflict of interest.
2. Deliberating or voting on a proposal or application by a Proposer as to whom the person has a conflict of interest.
3. Negotiating on behalf of CalMHSA with a Proposer as to whom the person has a conflict of interest.
4. Attempting to influence, directly or indirectly, a decision or selection by CalMHSA with regard to a Proposer as to whom the person has a conflict of interest.

SECTION 5: REPORTING A CONFLICT OF INTEREST

When a person with influence or decision making power first becomes aware of a conflict of interest or potential conflict of interest regarding a matter before CalMHSA or a committee or panel thereof, he or she must notify CalMHSA’s Executive Director. This notification shall include a description of the material facts relating to the conflict of interest. The Executive Director will determine if a conflict of interest or potential conflict of interest exists and the appropriate action to take.

When a Board Member has a conflict regarding a matter before the Board or Committee, as the issue is called, the Board Member must state on the record that he or she has or may have an interest in the matter, that he or she has not participated in any discussions, and he or she will not

be participating in the matter. The Board Member should then leave the room while the matter is considered.

The fact of the disclosure and the Board Member's abstention from the matter will be recorded in the minutes of the Board or Committee meeting.

Each Board Member is personally responsible for his or her conduct and can be prosecuted civilly and criminally for violations under the California Political Reform Act of 1974, among other laws. Board Members may contact the Fair Political Practices Commission, the State enforcement agency, directly to discuss their individual issues. Resources available from the Fair Political Practices Commission include www.fppc.ca.gov and 1-866-ASK-FPPC.

Staff members, contractors, consultants, or agents of CalMHSA who identify a conflict of interest or potential conflict of interest, must notify the Executive Director immediately.

SECTION 6: ANNUAL REPORTING REQUIREMENTS

All persons identified in the Appendix to CalMHSA's Conflict of Interest Code must file a Form 700, Statement of Economic Interest, in accordance with the California Political Reform Act of 1976.

To assist in the early identification of possible conflicts, Board Members must file an annual statement listing all organizations which they are affiliated with as an employee, director or officer. The statement should be updated when any changes occur.

SECTION 7: COUNTIES AS SERVICE PROVIDERS: ELIGIBILITY REQUIREMENTS

Member Counties or Cities are eligible enter into contracts with CalMHSA as Proposers or Sub-Contractors if the following requirements are adhered to: The County's or City's representative on CalMHSA's Board is required to recuse him or herself from any participation or consideration of the contract before the Board, Committee or Review Panel considering the matter; and the Board member may not participate in any way in the creation of the scope of work to be included in the RFP, presentation of the proposal in response to the RFP, discussion of the proposal with other Board Members or staff of CalMHSA, or participation in the vote on the RFP. The recusal requirement applies to Committee meetings as well as Board meetings.

STATEMENT OF NON-CONFLICT OF INTEREST

CalMHSA

Request for Proposals/Applications No. _____
[name of program or project]

I acknowledge that I have been appointed as a member of the Review Panel (“Reviewer”) to review proposals submitted in response to CalMHSA Request for Proposals (RFP) No. ____.

I understand that Reviewers must be free of any real or perceived conflict of interest. For purposes of this Statement, a conflict of interest exists where there is any relationship between a Reviewer and a Proposer or Sub-Contractor of a Proposer that could interfere with the ability of the Reviewer to exercise objectivity in the evaluation process.

I understand that when a Reviewer with a conflict of interest has participated in the Review Panel the results may be tainted and may require the re-initiating the evaluation process.

As used in this document, “Proposer” means a person or organization responding to the Request for Proposals listed above. Throughout this document, “Sub-Contractor” means a current sub-contractor of the Proposer, or a sub-contractor under a proposed agreement with the Proposer.

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

- Has a monetary or personal interest in the outcome of the evaluation process regarding the proposals.
- Is employed or has been employed by a Proposer or has a close relative (spouse, parent, child, or sibling) who is so employed by the Proposer.
- Is employed or has been employed by a Sub-Contractor or has a close relative (spouse, parent, child, or sibling) who is so employed by the Sub-Contractor.
- Is or has been a consultant to the Proposer or a Sub-Contractor.
- Is or has been a student, intern, trainee, volunteer or any other non-paid staff placed at a program of the Proposer or a Sub-Contractor.
- Has a close personal relationship with an individual or individuals employed at, placed at, or volunteering at a program of the Proposer or a Sub-Contractor.
- Is currently receiving or has previously received services from a Proposer or a Sub-Contractor.

- Has a spouse, parent, child, or sibling who is currently receiving or who has previously received services from a Proposer or a Sub-Contractor.
- Has a close personal relationship with an individual who is currently receiving or who has previously received services from a Proposer or a Sub-Contractor.
- Has submitted or been directly or indirectly involved in preparing the proposal of a Proposer.

I have read the above statements regarding conflict of interest. Further, I have reviewed the following list of Proposers that have submitted proposals in response to the CalMHSR RFP No. _____ that are under consideration by this RFP Evaluation Panel:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

and Sub-Contractors:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

After due consideration and review of the above list,

1. I affirm that to the best of my knowledge neither I, any member of my immediate family, nor a person with whom I have a close personal relationship has a material personal or financial interest or fiduciary relationship with any Proposer or Sub-Contractor under a proposal being considered by this RFP Review Panel.
2. I affirm to the best of my knowledge that there is no conflict or potential conflict of interest that would preclude me from participating in this evaluation process and in

rendering a fair and impartial evaluation and that none of the circumstances or situations that may create a real or perceived conflict of interest exist.

3. I further certify that I have no bias, whether positive or negative, toward any Proposer or Sub-Contractor and there exists no circumstance that would prevent me from evaluating each and every proposal under consideration by this RFP Review Panel solely on its merits.
4. I further agree to notify CalMHSA's Executive Director if at any time during this evaluation process, my personal, financial, or fiduciary relationship to one of the Proposers or Sub-Contractors is altered and a real or perceived conflict of interest should arise or I am no longer able to affirm that I can render a fair and impartial evaluation free of bias.

Name: _____
Reviewer's Signature Date

Name: _____
Print Reviewer's Name Title

CONFLICT OF INTEREST CODE
FOR
CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

Resolution No. 09-01

I. Background

The political Reform Act, Government Code Section 81000, et, seq., requires state and local government agencies to adopt and promulgate Conflict of Interest Codes. The Fair Political Practices Commission has adopted a regulation, 2 Cal. Code of Regulations/Section 18730, which contains the terms of a standard Conflict Of Interest, which can be incorporated by reference, and which may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearing. Therefore, the terms of 2 Cal. Code of Regulations/Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission, along with the attached Appendix in which officials and employees are designated and disclosure categories are set forth, are hereby incorporated by reference and constitute the Conflict of Interest Code of the California Mental Health Services Authority (CMHSA).

II. Designated Positions

Pursuant to the standard code all designated employees shall file their statements of economic interests with CMHSA which shall make the statements public inspection and reproduction (Government Code Section 82008).

III. Disclosure Categories

Individuals specified under these categories shall disclose any relevant information concerning investments in, source of income from, or his or her status as a director, officer, partner, trustee, employee, or any position of management in any business entities described below.

For the purpose of this code, the following disclosure categories are established:

- Category 1. Business entities which are of the type to supply to CMHSA materials, products, supplies, commodities or equipment utilized by the CMHSA.

- Category 2. Business entities which are of the type to supply to CMHSA services, including professional services, utilized by CMHSA.
- Category 3. Business entities engaged in the business of insurance including, but not limited to, insurance companies, carriers, holding companies, underwriters, brokers, solicitors, agents, adjusters, claims managers and actuaries.
- Category 4. Financial institutions including, but not limited to, banks, savings and loan associations and credit unions which are located in, doing business in, plan to do business in, or have done business in the jurisdiction of CMHSA.
- Category 5. Business entities or persons who have filed a claim, or have a claim pending, against CMHSA or any member of CMHSA.
- Category 6. All interests in real property located within the jurisdiction of CMHSA.

Date Adopted:

Date of Last Revision: N/A

Replaces Resolution No: N/A

Ayes: _____ Noes: _____ Abstains: _____ Absent: _____

NAME

TITLE

DATE

APPENDIX

TO
CONFLICT OF INTEREST CODE
OF

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY

Designated Positions

Disclosure Categories

Members of the Board of Directors (including all officers)	All
Alternate Members of the Board of Directors	All
Administrator	All
Consultants*	All
General Counsel	All
Legal Position	All
Auditor	All

*With respect to Consultants, the President of the Board, in the absence of an Administrator, may determine in writing that a particular consultant, although a designated person is hired to perform a range of duties that are limited in scope and thus is not required to comply with the disclosure requirements described in this Section. Such determination shall include a description of the consultant's duties and based upon that description, a statement of the extent of disclosure requirements. A copy of this determination shall be retained by the Joint Powers Authority. Nothing herein excuses any such consultants from any other provisions of the Conflict of Interest Code.

- (1) If these Designated Positions are business firms, the Statement shall be filed by the individual in the firm who has primary responsibility for conducting the firm's business activities for CMHSA.
- (2) "Consultants" shall include any natural person who provides, under contract, information, advise, recommendation or counsel to a state or local government agency.

ADMINISTRATIVE MATTERS
Agenda Item 8.C.

SUBJECT: Draft Participation Agreement

BACKGROUND AND STATUS:

At the July 15, 2010 board meeting members took action to approve the Program Participation Agreement and as such, CiMH indicated that they would complete their first draft to be presented at the September 10, 2010 board meeting.

RECOMMENDATION:

For discussion and/or action should action be deemed appropriate.

REFERENCE MATERIALS ATTACHED:

- Draft CiMH Participation Agreement *(to follow under separate cover)*

ADMINISTRATIVE MATTERS
Agenda Item 8.D.

SUBJECT: Draft Core Values

BACKGROUND AND STATUS:

In drafting and finalizing the CalMHSA Purpose and Vision statements, it was determined that a Values Statement was needed as well. A statement was presented and discussed at the August 12, 2010 board meeting; the following statement incorporates comments made at that meeting:

CalMHSA shall continually promote:

- *Systems and services that strengthen community mental health;*
- *Efficiency, expertise, innovation, accountability and quality;*
- *Transparency and stakeholder input;*
- *Prevention and early intervention*
- *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.*

RECOMMENDATION:

For discussion and/or action should action be deemed appropriate.

REFERENCE MATERIALS ATTACHED:

- None

CALMHSA – GENERAL DISCUSSION
Agenda Item 9

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.

RECOMMENDATIONS:

For discussion and/or action should action be deemed appropriate.

REFERENCE MATERIALS ATTACHED:

- None