ALCOHOL, DRUG & MENTAL HEALTH SERVICES
CAROL BURTON, LMSW, INTERIM DIRECTOR

WELLNESS • RECOVERY • RESILIENCE

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MHSA STAKEHOLDER GROUP

Friday March 23, 2018
2:00-4:00pm
2000 Embarcadero Cove, Oakland

Alvarado Niles Conference Room – 5th Floor

To participate by phone, dial-in to this number: (605) 475-4834
Participant access code: 102839

MISSION	VALUE STATEMENT	FUNCTIONS
The MHSA Stakeholder Group advances the principles of the Mental Health Services Act and the use of effective practices to assure the transformation of the mental health system in Alameda County. The group reviews funded strategies and provides counsel on current and future funding priorities.	*We maintain a focus on the people served, while working together with openness and mutual respect.*	The MHSA Stakeholder Group: • *Reviews* the effectiveness of MHSA strategies • *Recommends* current and future funding priorities • *Consults* with BHCS and the community on promising approaches that have potential for transforming the mental health systems of care • *Communicates* with BHCS and relevant mental health constituencies.

MEETING WILL START AT 2:00 PM

I. 2:00 pm Introductions & Updates

II. 2:15 pm MHSA Audit Report (http://www.auditor.ca.gov/pdfs/reports/2017-117.pdf)

III. 3:00 pm Innovative Programs - Stakeholder Roles and Input Process

- Review Projects and Proposals
- Make recommendations to BHCS
- Communication to community re. MHSA programs and stakeholder input process
- INN Subcommittee –Review and Evaluation

Attached Documents:

1. MHSA Audit Fact Sheet
2. MHSA Audit Chart Table A: The 59 Local Mental Health Agencies' MHSA Fund Balances FY2015-16 (p.46 & 47)
3. FY18-20 MHSA Budget
4. INN Frequently Asked Questions (FAQ)
5. MHSA Stakeholder Group Minutes (2/23/18)

Next Meetings: April 27, 2018; May 25, 2018

COMMITMENT
INTEGRITY
LEADERSHIP

February 27, 2018
Report 2017-117

FACT SHEET

Elaine M. Howle *State Auditor*

CONTACT: *Margarita Fernández | (916) 445-0255 x 343 | MargaritaF@auditor.ca.gov*

Mental Health Services Act

The State Could Better Ensure the Effective Use of Mental Health Services Act Funding

Background

To provide effective services and treatment for those who suffer from mental illness or who are at risk of mental illness, in 2004 California voters approved Proposition 63—the Mental Health Services Act (MHSA). The act imposes a 1 percent income tax on individuals earning more than $1 million a year in order to expand existing mental health programs and services at the local level. In fiscal year 2015–16, the MHSA generated $1.5 billion, of which the State allocated $1.4 billion to the 59 county and local mental health agencies (local mental health agencies). We evaluated how two state entities, the Department of Health Care Services (Health Care Services) and the Mental Health Services Oversight and Accountability Commission (Oversight Commission), oversee MHSA funding. We also assessed how three local mental health agencies—Alameda, Riverside, and San Diego counties—monitor projects that they support with MHSA funding.

Key Recommendations

- Health Care Services should do the following:
  - » Ensure that local mental health agencies spend MHSA funds in a timely manner by implementing policies and processes to reallocate any MHSA funds that are unspent within the statutory time frames, clarify that the interest earned on unspent MHSA funds is subject to reversion requirements, and establish an acceptable MHSA reserve level.
  - » Regularly analyze fund balances to identify excess fund balances and distribute those funds accordingly.
  - » Implement fiscal and program oversight of local mental health agencies.
- The Oversight Commission should continue discussions on innovative approaches to meeting requirements of the MHSA, complete internal program review processes, and establish statewide outcome metrics.

Key Findings

- Health Care Services has not provided effective direction to local mental health agencies on how to spend MHSA funds.
  - » It has not developed a process for recovering MHSA funds from local mental health agencies after time frames for spending the funds have elapsed—agencies maintain excessive MHSA reserves and have accumulated $2.5 billion in unspent funds as of fiscal year 2015–16 of which they should have returned over $230 million to be redistributed to agencies.
  - » There is no guidance in how local mental health agencies should treat interest they earn on MHSA funds and thus, agencies accumulated over $80 million in interest on unspent MHSA funds. Also, the three agencies we visited did not have policies on how to spend interest earned.
  - » Because it has not required local mental health agencies to adhere to a standard reserve level, agencies hold reserves of MHSA funds—$535 million as of fiscal year 2015–16.
  - » Although it knew of a $225 million fund balance in the state Mental Health Services Fund, it had not determined whether the balance was owed to local mental health agencies or was an accounting error.
- Health Care Services inadequately oversees the MHSA funds that local mental health agencies receive.
  - » It has not enforced reporting deadlines—only one of the 59 agencies submitted its fiscal year 2015–16 annual report on time.
  - » Although it developed a fiscal audit process in 2014, its audits focus on data and processes that are at least seven years old, and has yet to develop regulations to allow agencies to appeal findings.
- Although the Oversight Commission is implementing processes to evaluate the effectiveness of MHSA-funding programs, it still needs to develop guidance on the Innovation program approval process, complete an internal process for reviewing reports to ensure data is reliable and timely, and develop metrics to evaluate the outcome of the triage grants on a statewide level.

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Table A
The 59 Local Mental Health Agencies' MHSA Fund Balances
Fiscal Year 2015–16

LOCAL MENTAL HEALTH AGENCIES	COMMUNITY SUPPORT	PREVENTION	INNOVATION	WORKFORCE TRAINING	CAPITAL FACILITIES	RESERVE	INTEREST	TOTAL
Alameda County	$49,485,000	$11,454,000	$9,015,000	$2,933,000	$9,890,000	$18,066,000	$3,896,000	$104,739,000
Alpine County	3,173,000	1,503,000	535,000	450,000	922,000	541,000	361,000	7,485,000
Amador County	3,172,000	793,000	737,000	191,000	330,000	1,102,000	29,000	6,354,000
City of Berkeley	6,467,000	1,417,000	596,000	306,000	1,397,000	1,612,000	67,000	11,862,000
Butte County	577,000	—	1,189,000	57,000	293,000	2,458,000	271,000	4,845,000
Calaveras County	3,656,000	1,016,000	346,000	74,000	49,000	975,000	82,000	6,198,000
Colusa County	4,135,000	743,000	533,000	26,000	—	418,000	340,000	6,195,000
Contra Costa County	25,863,000	4,179,000	4,301,000	783,000	952,000	7,125,000	2,753,000	45,956,000
Del Norte County	2,078,000	352,000	545,000	368,000	801,000	813,000	14,000	4,971,000
El Dorado County	5,099,000	2,345,000	2,101,000	81,000	462,000	1,898,000	142,000	12,128,000
Fresno County	52,279,000	14,152,000	6,181,000	3,708,000	6,243,000	12,824,000	—	95,387,000
Glenn County	2,707,000	391,000	112,000	210,000	—	89,000	2,000	3,511,000
Humboldt County	183,000	2,108,000	969,000	317,000	509,000	1,169,000	119,000	5,374,000
Imperial County	3,075,000	2,915,000	1,765,000	177,000	416,000	130,000	—	8,478,000
Inyo County	1,675,000	433,000	86,000	250,000	139,000	649,000	94,000	3,326,000
Kern County (2014–15)	*26,704,000*	*13,533,000*	*5,734,000*	*521,000*	*1,634,000*	*12,365,000*	*586,000*	*61,077,000*
Kings County	5,585,000	295,000	1,430,000	—	1,112,000	2,138,000	382,000	10,942,000
Lake County (2011–12)	*627,000*	*322,000*	*90,000*	*443,000*	*576,000*	*1,139,000*	*31,000*	*3,228,000*
Lassen County	1,770,000	630,000	462,000	—	649,000	805,000	3,000	4,319,000
Los Angeles County (2014–15)	*233,051,000*	*140,582,000*	*84,319,000*	*33,742,000*	*29,397,000*	*192,054,000*	*24,465,000*	*737,610,000*
Madera County (2014–15)	*7,942,000*	*1,516,000*	*890,000*	—	—	*34,000*	*78,000*	*10,460,000*
Marin County	9,681,000	1,778,000	2,100,000	608,000	1,768,000	2,175,000	570,000	18,680,000
Mariposa County*	(1,355,000)	825,000	434,000	149,000	(192,000)	—	2,000	(137,000)
Mendocino County	799,000	1,219,000	1,452,000	311,000	584,000	2,198,000	23,000	6,586,000
Merced County	8,715,000	4,136,000	2,193,000	211,000	4,864,000	4,104,000	525,000	24,748,000
Modoc County	1,187,000	880,000	245,000	126,000	512,000	472,000	75,000	3,497,000
Mono County	144,000	994,000	536,000	554,000	1,053,000	1,672,000	96,000	5,049,000
Monterey County (2013–14)	*8,867,000*	*1,214,000*	*2,437,000*	—	—	*3,063,000*	*16,000*	*15,597,000*
Napa County	668,000	46,000	1,196,000	72,000	400,000	898,000	167,000	3,447,000
Nevada County (2013–14)	*926,000*	*1,011,000*	*364,000*	*55,000*	—	*1,142,000*	*266,000*	*3,764,000*
Orange County	92,495,000	38,639,000	21,044,000	941,000	6,587,000	70,922,000	11,303,000	241,931,000
Placer County	11,884,000	2,170,000	945,000	—	1,994,000	2,706,000	1,504,000	21,203,000
Plumas County (2013–14)	*4,384,000*	*856,000*	*638,000*	*171,000*	*95,000*	*1,037,000*	*157,000*	*7,338,000*
Riverside County	35,653,000	20,341,000	11,370,000	3,238,000	14,916,000	28,525,000	6,578,000	120,621,000
Sacramento County	76,487,000	13,740,000	10,700,000	2,155,000	3,523,000	19,392,000	—	125,997,000

LOCAL MENTAL HEALTH AGENCIES	COMMUNITY SUPPORT	PREVENTION	INNOVATION	WORKFORCE TRAINING	CAPITAL FACILITIES	RESERVE	INTEREST	TOTAL
San Benito County	$4,466,000	$1,575,000	$1,080,000	$176,000	$1,489,000	$932,000	$356,000	$10,074,000
San Bernardino County	75,783,000	11,054,000	4,340,000	307,000	4,860,000	22,152,000	2,423,000	120,919,000
San Diego County	93,767,000	8,966,000	17,148,000	406,000	11,769,000	42,193,000	11,031,000	185,280,000
San Francisco County	13,303,000	343,000	3,848,000	—	—	4,325,000	597,000	22,416,000
San Joaquin County	6,896,000	9,525,000	5,041,000	1,233,000	5,573,000	11,655,000	1,998,000	41,921,000
San Luis Obispo County	8,285,000	1,448,000	1,375,000	158,000	—	2,813,000	667,000	14,746,000
San Mateo County	9,693,000	1,528,000	5,540,000	799,000	—	600,000	266,000	18,426,000
Santa Barbara County†	1,810,000	157,000	2,047,000	188,000	262,000	2,023,000	(30,000)	6,457,000
Santa Clara County (2014–15)	*71,879,000*	*18,719,000*	*11,574,000*	*(45,000)*	*9,269,000*	*20,118,000*	*1,704,000*	*133,218,000*
Santa Cruz County (2013–14)	*4,241,000*	*3,409,000*	*720,000*	*265,000*	*2,748,000*	*3,470,000*	*530,000*	*15,383,000*
Shasta County	4,083,000	2,985,000	2,524,000	22,000	465,000	—	45,000	10,124,000
Sierra County (2014–15)	*2,315,000*	*1,100,000*	*370,000*	*20,000*	*542,000*	*607,000*	*1,665,000*	*6,619,000*
Siskiyou County	1,705,000	582,000	1,055,000	153,000	—	940,000	236,000	4,671,000
Solano County	15,659,000	5,034,000	2,988,000	597,000	420,000	2,725,000	473,000	27,896,000
Sonoma County	3,412,000	1,631,000	551,000	—	—	905,000	106,000	6,605,000
Stanislaus County	18,408,000	4,513,000	2,520,000	144,000	868,000	500,000	—	26,953,000
Sutter-Yuba joint powers authority (2012–13)†	*1,610,000*	*1,288,000*	*1,903,000*	*813,000*	*(267,000)*	*272,000*	*152,000*	*5,771,000*
Tehama County	818,000	1,302,000	137,000	102,000	346,000	546,000	5,000	3,256,000
Tri-City joint powers authority	10,239,000	980,000	989,000	204,000	25,000	3,517,000	97,000	16,051,000
Trinity County	1,605,000	109,000	—	11,000	—	493,000	106,000	2,324,000
Tulare County	27,888,000	3,571,000	5,453,000	721,000	1,517,000	7,252,000	2,971,000	49,373,000
Tuolumne County	2,538,000	275,000	255,000	3,000	120,000	411,000	31,000	3,633,000
Ventura County	15,099,000	5,171,000	2,284,000	728,000	2,940,000	9,499,000	—	35,721,000
Yolo County (2014–15)	*6,093,000*	*2,808,000*	*499,000*	*478,000*	*1,893,000*	*514,000*	*288,000*	*12,573,000*
Totals	**$1,091,433,000**	**$376,601,000**	**$251,831,000**	**$60,711,000**	**$136,714,000**	**$535,172,000**	**$80,714,000**	**$2,533,176,000**

Sources: The local mental health agencies' MHSA annual reports for fiscal year 2015–16.

Note: As of December 2017, nine of the 59 local mental health agencies had yet to submit their fiscal year 2015–16 annual reports, and an additional three had not finalized their annual reports in response to Health Care Services' concerns. Therefore, we relied on prior years' annual reports for 12 local mental health agencies to complete this table as shown below:

FISCAL YEAR OF MOST RECENT ANNUAL REPORTS	LOCAL MENTAL HEALTH AGENCIES
2014–15	Kern County, Los Angeles County, Madera County, Santa Clara County, Sierra County, Yolo County
2013–14	Monterey County, Nevada County, Plumas County, Santa Cruz County
2012–13	Sutter-Yuba joint powers authority
2011–12	Lake County

* Mariposa County indicated that its past overspending of Community Support funding resulted in it reporting a negative total balance.

† We did not contact other local mental health agencies with negative balances in individual categories because their total balances were positive.

Mental Health Services Act
FY18-20 Fiscal Outlook -DRAFT

MHSA Funding Estimates

For CSS, PEI, and INN only (in millions)

SOURCES	FY 17/18	FY 18/19	FY19/20
1. Available Unexpended Funds	$63.6	$47.0	$25.5
2. Current Year MHSA State Allocation	$67.3	$66.7	$69.0
Total Available in MHSA Trust Fund	**$130.9M**	**$113.7M**	**94.5**

USES	FY 17/18	FY 18/19	FY19/20
1. MHSA Programs (CSS, PEI, INN)	$83.9	$88.2	$88.0
YEAR-END UNEXPENDED FUNDS	**$47.0M**	**$25.5M**	**$6.5**
PRUDENT RESERVE BALANCE	$36M	$36M	$36M

FACT SHEET

Innovation (INN) Guidelines
Effective Oct. 1, 2015

This fact sheet directly quotes the INN proposed guidelines and resource materials that were issued on July 2015. Visit: http://mhsoac.ca.gov/document/2016-03/innovation-regulations

I. PRIMARY PURPOSE

Innovation (INN) must be used for the following primary purposes:

- Increase access to underserved groups
- Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

Counties must select one or more of these purposes for each INN project. The selected purpose(s) will be the key focus for learning and change.

II. DEFINITIONS

An INN project is one that contributes to learning, rather than a primary focus on providing a service, in one or more of the following three ways:

- Introduces new mental health practices/approaches including prevention and early intervention that have never been done before, or
- Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community, or
- Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.

An INN project may introduce a novel, creative, and/or ingenious approach to a variety of mental health practices, including those aimed at prevention and early intervention.

Restrictions: A practice/approach that has been successful in one community mental health setting cannot be funded as an INN project in a different community even if the practice/approach is new to that community, unless it is changed in a way that contributes to the learning process. Merely addressing an unmet need is not sufficient to receive funding under this component.

III. PLANNING PROCESS

Scope: INN projects may address issues faced by children, transition age youth, adults, older adults, families (self-defined), neighborhoods, tribal and other communities, counties, multiple counties, or regions. The project may initiate, support and expand collaboration and linkages, especially connections between systems, organizations and other practitioners not traditionally defined as a part of mental health care. The project may influence individuals across all life stages and all age groups, including multigenerational practices/approaches.

New INN Project Approval: INN project approval involves a two-step process. Fully developed INN project ideas can either be included in the County's Three Year or Plan Update or be submitted as a stand-alone document that's posted for 30-day public comment and then submitted to the County Board of Supervisors for approval. Once a County has received Board approval it shall submit an INN Project Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for approval of INN project funds. The MHSOAC approves all INN funds for each new INN Project. INN funds cannot be spent until the MHSOAC approves the INN project and budget.

Time Limits: Each INN project has up to 5 years for implementation.

Regional Collaboration: Collaboration among counties is encouraged under INN. Two or more counties may work together on a joint INN project.

Non-Supplant: According to CCR, Title 9, Division 1, Chapter 14, section 3410, the MHSA non-supplant requirements related to county expenditures must be met.

V. REPORTING & EVALUATION

Data Collection: INN project reports must include participants' demographic data on age, race, ethnicity, primary language, sexual orientation, disability, veteran status, gender, and other relevant data.

Evaluation: The evaluation component of each INN project shall include INN project outcomes related to the selected primary purpose and INN activities that contributed to successful outcomes. INN project results shall be disseminated to stakeholders. There shall be stakeholder involvement in evaluation and continuation of INN projects.

Sustainability Planning: If an INN project has proven to be successful and a county chooses to continue it, the work plan must transition to a different funding. Counties may consider integrating a successful INN project into other components when planning for the future. County shall consider how to provide continuity for participants with SMI after the implementation of INN project.

For more information on ACBHCS Innovative Programs visit www.acinnovations.org

Alameda County Mental Health Services Act Stakeholder's Meeting
February 23, 2018 • 2:00 pm - 4:00 pm
Alvarado Niles Room, 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

Meeting called to order by Chair **Linda Leung Flores**

Present Representatives: Viveca Bradley (POCC), Margot Dashiell (AC Family Coalition), Alane Friedrich (Mental Health Board), Janet King (Native American Health Center), Elaine Peng (NAMI Chinese, MHACC (Mental Health Association for Chinese Communities)), Liz Rebensdorf (NAMI), Tracy Hazelton (MHSA Division Director, BHCS), Linda Leung Flores (MHSA Senior Planner, BHCS) and Terri Kennedy (Administrative Assistant for MHSA Division, BHCS).

Phone-in participants: Karen Grimsich (City of Fremont), James "Scotty" Scott (Reaching Across)

ITEM	*DISCUSSION*	*ACTION*
MHSA Plan & Innovations PowerPoint Presentation and Q&A (Linda Leung Flores and Tracy Hazelton)	Feedback on presentation: Margot D: • It would be helpful for the slides showing where MHSA funding is already in play to feature how impacted these current programs are (i.e. Woodroe, BOSS, etc.)- how full are they? Is there a waitlist? (On slides 3-6) • I would like to see the demographics of the survey participants. Was the family member population surveyed? Did they do outreach to get survey responses, or just POCC? Viveca B.: • In regard to the PEI FY 18-20 changes, what is "African"? What languages will be picked to offer? • Let's think about labels to differentiate between African and African American, and let the public know the services are for Non-English speaking or Non-American born African populations.	• Liz R. to set-up and meet with a subcommittee of Stakeholders to review the prior INN projects evaluations to review and extract what worked with these projects *A sign-up sheet was passed around, Terri typed and emailed to Linda.
INN projects updates & discussion (Linda Leung Flores and Tracy Hazelton)	**Concerns expressed around implementation and sustainability for the INN projects:** • Where is the connection piece "missing link" to connect these projects with organizations who can keep them running? **Responses to the concerns and other updates:** • The best way for these projects to succeed is to have a BHCS System of Care pick them up after their INN grant is up. Of all of the past 18-month programs, only one moved forward past the grant time. The new projects proposed for funding have a much greater chance of stability because they're going to run for longer and because the people involved in the project are directors in BHCS who are already	

ITEM	*DISCUSSION*	*ACTION*
	investing in the projects in hopes of picking them up after the INN grant period has ended • There has been a change of regulations for INN project grants re: Evaluations and sustainability. These new regulations were considered when looking for projects to implement moving forward. • In April or May of this year, the Stakeholder Committee will be able to review the new INN project proposals going to the Oversight and Accountability Commission (OAC). RFPs are done after they OAC approves.	
Q&A about proposed INN project Community Assessment and Transport Team (Kate Jones, BHCS)	Feedback/Questions/Concerns about the proposed Community Assessment and Transport Team (CATT) INN Project: **Margot D.:** • The concept of changing the range of options when a 5150 is called and that you can medically clear clients in the ambulance is all great. • If they want to go to John George, Woodroe, will the ambulance staff know ahead of time that there are beds available? **Kate Jones:** Yes, ideally- that is the goal. **Margot D.:** • The concern is with the service area set for implementation. It's to start in an area that not of the highest need. Oakland has the highest need, so why wouldn't this start there? **Kate Jones:** This project is to start as a "smaller test of change". Hopefully we can start in San Leandro and Hayward, where the 5150s account for about 12-15% of the county's 5150 calls. Then we would consider expanding into Oakland after learning/adjusting/reworking before expansion. This allows for better preparation for the team and a chance to learn first. The Ashland/Cherryland area is underserved, and a lot of released inmates end up living in that area. BHCS also hopes that this pilot will help build a stronger connection with the police. Additionally, it was proposed today that we make this a 5 year project instead of a 3 year, with plans to expand services into Oakland in 2 ½ years with a different approach. **New pilot for Oakland:** We would like to reconfigure the pilot for CATT for Oakland (based on statistics) to include: • Looking to have 1 or 2 CATT teams or "Paramedics Plus" to focus on high utilizers	• Kate Jones will mention this suggested 1 ½ year launch date goal to the CATT project team on behalf of the Stakeholder committee.

ITEM	*DISCUSSION*	*ACTION*
	• Assess/differential diagnosis • Once cleared medically, get them matched to the appropriate care needed. **Margot D.:** • Why not start in Oakland, but on a smaller scale, in certain neighborhoods? **Kate Jones:** It's challenging for communities to accept that services are limited to specific areas (found that to be true with MET). Also, we really want the team to be experts before we come into the biggest city. **Viveca B.:** • This has potential to be a great program, and a "test-run" is always smart, but this is a huge amount of money to be spent on a "small test". • Another thing to think about in planning is how vastly different the population of the cities are. • Viveca thinks 1 ½ years is long enough to run before expanding into Oakland. She's willing to help in any way possible. She mentioned having contacts at the office of the Chief of Police she would gladly reach out to. **Kate Jones:** Will mention this suggested 1 ½ year launch date goal to the team on behalf of the Stakeholder committee. **Additional information from Kate Jones:** Goals: • Hoping to create more teams and get a chance to merge funds (i.e. Measure A funds) to keep the project going. • New project variation: Teams for high utilizers and teams for non-police transport, AM and PM teams, etc. • To serve individuals in accordance with their health plans Utilization of funds: • Can't afford RNs and EMTs, so only using EMTs for the project • Pay for clinicians • Paying for equipment and supplies • Paying for the vehicles Staff duties: • EMTs will do medical clearance • Clinicians will do psychiatric clearance • Drug involved incident- send to Cherryhill? • Alcohol involved incident- send to Emergency Room Sustainability:	

ITEM	*DISCUSSION*	*ACTION*
	• HCSA, Public Health and Environmental Health agencies are all very interested in this project and are discussing participation to help is succeed.	
Q&A about Wellness Centers (Jen Mullane and Kim Coady, BHCS)	**Margot D.** Concern: • She was at the Townhouse a lot in 2015, looking to attend the next visit with the Wellness Center Advisory Committee. She will investigate more before commenting, but her concern is with the level of engagement with the consumers who are there. What is the Townhouse hoping to achieve? Compliment: • The kitchen is working. They now offer breakfast and lunch, and that gets people in the door. **Viveca B.'s remarks:** • There is no engagement at the Townhouse, just a kitchen. There is a calendar posted with activities "scheduled" and none of the activities take place. People are just there sitting. Viveca has offered to teach an art class on several occasions, and got nowhere with that. She has attempted to start activities at both Lakehurst and the Townhouse with no avail. • James "Scotty" Scoot has a Townhouse in Fremont and it's working- that shows that this model CAN work. We should evaluate what they're doing. **Jen Mullane's remarks:** • These places were Creative Wellness Centers, but in 2012 the model changed. We take these concerns very seriously, as we left the contracts to allow creativity. • The momentum around implementing changes is picking up now with the involvement of the Advisory Committee. **Kim Coady's remarks:** • Will email notes from the Committee and demographic data to those in the Stakeholder Committee who are interested.	• Margot D. to continue involvement with the Wellness Center Advisory Committee and conduct further investigations on the current conditions. • Kim Coady will email notes from the Wellness Center Advisory Committee and demographic data to those in the Stakeholder Committee who are interested.

Next Stakeholder meeting: Friday, March 23rd from 2-4 p.m., Alvarado Niles Room.

MHSA Stakeholder Group Roster/ Composition
(Non-Staff Only)

First Name	Last Name	Agency/Affiliation	Gender/ Orientation	Consumer	Family	Provider	MH Board	Priorities Pop	Age: All	Age: C/Y	Age: TAY	Age: Adults	Age: Older Adults	Geographic: All	N	C	S	E
Alane	Friedrich	Mental Health Board	Female				1		All						N			
Viveca	Bradley	Pool of Consumer Champions	Female	1				Diverse/ Cultural Ethnic Grp; Homeless	All				OA		N			
James	Scott	Reaching Across	Male	1					All							C	S	E
Julia	Eagan	Telecare	Female			1			All									
Margot	Dashiell	Alameda County Family Coalition	Female		1			Diverse/ Cultural				A			N			
Liz	Rebensdorf	NAMI	Female		1							A			N			
Karen	Grimsich	City of Fremont	Female			1							OA			C	S	
Janet	King	Native American Health Center	Female			1		Underserved	All						N			
Sreyneang	Lim	Center for Empowering Refugees & Immigrants	Female		1			Underserved		C/Y	T				N			
Tracy	Murray	Area Agency on Aging	Female			1							OA	All				
Leah	Weinzimer	Partnerships for Trauma Recovery	Female			1		Underserved				A			N			
Elaine	Peng	NAMI, FERC	Female	1				Underserved	All								S	
Stakeholder Representation			**TOTALS**	3	3	5	1	5	5	1	1	3	3	1	7	2	3	1
Respresentation %				14%	14%	24%		24%	24%	5%	5%	14%	14%	5%	33%	10%	14%	5%

MHSA Stakeholder Guidelines	**Membership**	
1. Currently 12 members. Need total of 21 Members	**Number of members required:**	**21**
2. 25% Consumers; 25% Family members; 25% Providers.	**Number of current members :**	**12**
3. MHSA Stakeholder Group includes representation for:	**Number of members needed:**	**9**
a. The five Alameda County Supervisorial districts	**Need Diverse Cultural/ Ethnic Groups w/ Rep in Latino, Afghan, Pacific Islander Communities**	
b. Older Adult, Adult, TAY, and Children age groups		
f. Consumers		
g. Families		
h. Community Based Organizations (CBOs)		
i. Homeless population with Serious Mental Illness (SMI)		
j. Underserved populations		
k. Primary Care Providers		
l. Diverse Cultural and Ethnic groups		