

**MENTAL HEALTH SERVICES ACT (MHSA)
Stakeholders Meeting
December 17, 2004**

**Attachment 3 – Session #1
Group Feedback**

Number of Groups: 54

Participants: about 460	#
State Agency	31
County Agency	91
Local Mental Health Board	31
Legislative	4
Judicial	2
Law Enforcement/Probation	13
Mental Health Provider	104
Mental Health Consumer	70
Family Member of Adult Consumer	56
Family Member of Children/Youth Consumer	32
Organized Labor	12
Advocate Group or Individual	98
Other Statewide Organization	47
Other	45

Feedback was discussed following the questions on the feedback forms by the people working together at tables. First, the number and percent of the total responding to the question about agreement with relevant section of the draft document, Attachment C, Required Contents; County Requests for Funding for the Mental Health Services Act (MHSA) Planning (November 30, 2004), is shown. Not every table noted their level of agreement and even those at which everyone accepted the draft version as written had comments and revisions. Then the responses to each question are shown grouped together by similar topics, with the number of responses by topic shown in parentheses. Many groups provided more than one response to each section, so that the total responses will exceed the number of groups.

A. Planning must include consumers and families. (135 responses)

Attachment C, Section A is discussed in this section.

	#
All Agreed	35
Most Agreed	9
Some Agreed	4

Process (26)

Evaluation/Data (8)

- #3. Identify a source of data for finding the most underserved
- Require documentation how they outreach participation
- Cross reference and document the outreach efforts with the groups you contact
- Verification process to ensure that they are included, e.g., known addresses of consumers and organizations contacted
- Plans should be linked to measurement and accountability
- 1st sentence – need to add through implementation and evaluation
- Accountability – that consumers and family members validate it – reporting contact information
- Missing the validation process

Media/Education Process and Mechanisms (7)

- Provide guides and information to increase informed input
- Need to think of many vehicles such as web-based, mail surveys, clinics, to capture information
- Use developmentally appropriate mechanisms
- Capture geographically isolated in a survey for all stakeholders at all points of entry
- People outside of the system need to be contacted through media, meetings
- Mental Health Boards must distribute invitations and materials
- A.3. Add interactive website, public access TV to disseminate information and a public forum; also public libraries (essential for access to internet for low-income)

School Involvement (4)

- Use school settings to help identify needs
- Use school partners to reach consumers – youth and families
- Hold school-based meetings
- How does this integrate with services at public schools? Services must be integrated through PPS providers at the public schools – children and families are located at the schools

Meetings (3)

- Planning meeting in evenings and week-ends
- Make the meetings accessible with interpreters
- Designate the number of forums based on county size, concentration of population

Other (4)

- Pt. A.4 should say “encourage” the formation of groups, the groups should not be created by the county
- Define mechanics of involvements, i.e., procedures
- Provide prevention vs. crisis early on instead of last
- Need stronger direction from the State in all areas A-G

Diversity (19)

Cultural and Linguistic Competence (13)

- #5 should include translators/interpreters (3)
- How do we outreach to persons who don't speak English? (2)
- Literacy must not be a criterion
- State to assist counties in cultural competency areas of the underserved
- Do not forget cultural barriers
- Respect consumer/family culture
- Represent culturally diverse populations and populations that are not currently being served (census as model)
- Must consider under-represented (cultural, ethnic, etc.)
- There need to be many meetings all over the community that should be small to hear many consumers – they should be linguistically and culturally appropriate
- Cultural diversity and organizations and language competency
- Outreach to different cultures in their vocabulary and definition of mental illness

Diverse Populations (6)

- Add at end of sentence on bullet #3: "input of underserved and unserved populations; such as ethnic groups not represented in the census, recent immigrants, foster children, gays and lesbians, and homeless population"
- Planning process should include representation of diverse population
- Include homeless population
- Ensure diversity of population is represented by age, ethnicity, gender, language, socio-economics
- Need diverse representation of populations being served, including foster parents
- Inclusion is difficult but critically important

Consumers and Families (15)

Inclusion (7)

- Consumer voice should be included in all levels of decision making
- It is critical to ensure participation of consumers and families who don't belong to advocacy groups or previously underserved
- In #2, add consumers not served at all, homebound adults, viello/radio call-in access
- Family members need to have a stronger, more meaningful voice
- A4... active "or fully representative" consumer and family groups
- Client involved in process as well as implementation
- Obtain input from consumers of all socio-economic statuses – reach out to family and consumer groups

Planning (6)

- Planning must include family members and advocates for children and youth
- Obtain feedback from consumers at all levels of services, for example, inpatient, outpatient, residential, independence
- Vets representation and consumers must be invited to planning and rollout sessions and must include traditionally excluded groups (foster youth) and representative

organizations, including include NAMI: message is all direct and indirect consumers should be included

- Emphasize the client as the focus throughout the whole process
- Consumers should be central in the planning process – going into IMDs to get input from those consumers – other institutions
- A.1. Process should be consumer-driven – consumers should be on equal terms with County staff and providers in this process

Other (2)

- One client has problem with involvement of families in planning process because historically families used to commit mental health clients, so there is traditionally a “controlling aspect” of families over consumers
- Add statement that consumers agree with process developed by family

Outreach (12)

- A.3. Outreach strategies to underserved and unserved: create a team to go out to parks and areas where homeless unserved people can be found to capture their voice
- Outreach to non-traditional settings and places that serve poor
- Counties should go where consumers are and not expect consumers to go to the county
- Input and outreach to consumers who are not currently involved
- Where are the gaps in which individuals are not getting help?
- Need to be committed to something more than reaching out
- Include a provision and timelines for outreach, specifically when information will be distributed and when input will be required
- Outreach beyond already served – unserved – including identifying those at risk for future severe mental illness, e.g., FAS
- Street outreach
- Need to do outreach
- Helpful to describe outreach
- Have counties contact various local networks to ensure a large base of consumers and family

Definitions (13)

- Change wording to a mandate of must (A.5.) – not an option (2)
- “Meaningfulness” is too weak – consumers/family input will be incorporated into plan
- Change language around “meaningful involvement” to client-centered involvement
- Not clear what “meaningful” means – give an example
- Expand “consumers and families” to include “or other support service”
- Need to define consumers, stakeholders and families
- Simplify the description of required contents, Attachment C – “How will your county include consumers and families of adults and children in the MHSA planning process?” and “How is input translated into the final plan?”
- Define and give examples of stakeholder titles

- Provide a clear and precise definition of “full partners” to ensure a threshold of involvement
- We would like to see description of how the stakeholder process would work – ask the counties and cities to be very very specific – specify appropriate outreach to homeless population – put this language in #2 and #4
- “Describe” is a stronger word than “indicate”
- Spell out categories of consumer involvement – adults, older adults, youth, transition age, homeless, to ensure broad consumer and family representation

Age Groups (10)

Youth (7)

- Make sure specific outreach to transition age youth
- Remember youth
- Include youth as planners
- Add youth consumers – fix reference to consumers to include adults and children
- Pt. A – direct reference to youth should be included
- There is no specific identification of youth as a stakeholder
- Make sure youth are part of the planning process so every county plan includes

Older Adults (2)

- Include older adults, an underserved community that needs representation
- Identify breadth of consumers to be included in plan, be sure no age groups is left out, especially seniors, or those helping seniors

Other (1)

- All ages and types of consumers need to be specifically defined or not precluded from the planning process

Underserved/Unserved (9)

- Consumers who are incarcerated or institutionalized (3)
- State and County need to get prison inmates to have a voice
- Include consumers, families and older adults, all underserved communities that need representation
- Underserved “populations” should be changed to include underserved individuals regardless of what group they fall into
- Include language in header under or unserved population
Each county needs to get specific about who is the underserved since many do not do an effective job of outreach
- Researcher can help find underserved – weight the formula so they can be found
- Be sensitive to the ways to include underserved populations

Other Stakeholders (9)

- We need more meaningful involvement throughout the whole process
- 1/4 counties should list participants by organizations, agencies, etc.
- Named stakeholders, like providers, are not included in the major list

- Include providers/doctors
- Include line staff from multiple systems
- Include child care
- Include merchants and other community members who meet consumers
- Include spirituality
- Include law enforcement

Incentives (5)

- Provide financial support to improve participation by consumers, as well as transportation (2)
- Travel, stipend, stigma need to be taken into consideration
- Provide compensation for involvement
- This process is meaningless without client and families funding starting January 1 and reimbursement for significant involvement

Funding (4)

- There should be seed money upfront for planning of first phase
- Provide money upfront for staff
- Organizers need to be paid and available; dedicate staff to take into consideration to include underserved population
- What is the minimum amount of money, so small counties know how to plan?

Technical Assistance (2)

- State to provide technical assistance and funding and tools and accountability to reach underserved populations
- Have technical assistance on website for all counties to show how to include family/consumer network, i.e. focus groups

Other (11)

- Owners who run institutions to be involved
- Families and clients sometimes have fundamental disagreements regarding medical model treatment such as voluntary vs. involuntary place
- Sensitivity to judicial system
- Educate general public so they can recognize that they too need help
- Church constituent identification
- Community partnership with grassroots, advocates and training to become an advocate
- Please include city jurisdictions in all MHSA communications
- Include wraparound services
- Mobility of services, universal plan, standardized eligibility
- In principle we agree with the draft – find it outstanding – want to see revisions we suggest
- What will training be? Can the county and Client Networks really get them involved and trained?

B. Planning process must be comprehensive and representative. (208 responses)
Attachment C, Section B and Attachment 1, Other Stakeholder Participation, are discussed here

	#
All Agreed	28
Most Agreed	10
Some Agreed	4

Businesses, Unions, Advocates, Neighborhood Groups, Faith Community, Etc. (40)

Faith Organizations (9)

- Faith Community (6)
- Churches
- Spiritual leaders
- Add religious/spiritual leaders

Advocates (8)

- Add unions/labor (6)
- Add Gray Panthers
- Add self-directed advocate category

Alternative Supports (5)

- Anyone who can help clients integrate into community
- Include private sector nutrition
- Private sector physical fitness
- Community care licensing board and care homes, payees, conservators
- Outreach to substance abuse recovery groups

Business (5)

- Business associations (2)
- Employers
- Chamber of Commerce
- Add business associations or employment agencies

Other (13)

- Neighborhood associations (3)
- Professional groups
- Include media (i.e., news, advertising, radio, TV)
- Must include legal from the very beginning to ensure compliance with the law and to ensure compliance does not slow down the process of contracts and implementation
- Cultural groups
- Add Native American groups
- Bring in foundations, First 5 and Advisory Council early in planning process
- Add private foundations
- Add First 5 under Youth
- Add VFW members to “others”

- Add coalitions and associations under other stakeholders

Education (18)

- Colleges and universities (4)
- Education (2)
- Add research universities
- Add adult education
- Take the education from Youth and Transition and make it its own category – add community college, university, special education, adult education, regional training programs, literacy training, childcare training, add PPS providers
- Add education under adult/transition age
- Add education for adult
- How does this integrate with services at public schools? Services must be integrated through PPS providers at the public schools – children and families are located at the schools
- Include K-12 (PPS) in this process for creation and assurance of seamless referral/prevention and intervention for students and families ¹
- Have two representatives for education, one for special education, one for general education
- Child care communities
- Add early childhood
- Add children development
- Include child care workers and preschool providers

Consumers/Families (18)

- Include sexual orientation and other diversity (2)
- Client helping client strategy
- Need input from folks in locked settings, including jails
- Executing this goal could be challenging – need to reach all the stakeholders especially mental health consumers' voices
- There needs to be a way to seek out those who are not represented
- Add family members
- Consumers and families must be full partners
- Where is socio-economic diversity?
- Add consumer/provider category
- Inpatient outreach needs to be included
- Outreach to people from diverse ethnic backgrounds
- Outreach to individuals where English is not a primary language
- Outreach to people of different ages
- Outreach to indigent populations
- Add developmentally disabled clients
- Add youth and adult homeless

¹ PPS = school counselors, school psychologists, school social workers (pupil personnel services (credential))

- Add consumers under youth, adults and older adults

CBOs (18)

- CBOs (3)
- Include non-profit providers in planning process (3)
- Add mentoring organizations (boys and girls clubs, boy and girl scouts) (2)
- CBOs should be in every sector
- Include community-based, public, private, non-profits – Head Start, Older and Adult Alcohol and Drug, Job Corps, Labor and full service workers, Housing (all ages), private developer
- Women's shelters and groups
- Add domestic violence organizations, CBOs that target specific populations
- Add Red Cross
- Add service clubs
- Add League of Women Voters
- Have list of cultural community groups that will be invited
- Add agencies and private providers
- Include community-based non-profit organizations who are committed to include people who are not usually represented and who are difficult to include

Mental Health Providers (17)

- Include mental health line staff under other stakeholders (3)
- Outreach to current mental health staff
- Add mental health staff to stakeholder list
- Should include direct service workers who have daily contact with clients
- Specify licensed mental healthcare providers, academic researchers involved in mental health
- Not comprehensive enough – missing mental health representatives
- Add psych professionals
- Add conservators and guardians
- Add administrator, workers
- Does not talk about contract providers
- Public and private agency staff at all levels, interns
- Must include all mental health providers outside the county system, such as community clinics and health centers as full partners
- Get as many prescribing providers in the community as possible
- Add treatment providers
- Add direct service providers

Other (Local) Governmental Agencies (15)

- Add recreation and parks (2)
- Add (local) welfare agencies for youth and adults (2)
- Add local government entities (2)
- Add regional centers (2)

- Add library
- Have a representative from the Board of Supervisors as a stakeholder
- Add public assistance and CalWORKs
- County Mental Health Board not to monopolize or dictate input from all
- Add City and County Human Relation Commissions
- Outreach to cities
- Go beyond Mental Health Board

Process and Documentation (15)

- Require some key agencies to be full partners
- Need to make public documentation of written record of stakeholders' recommendation for future implementation
- State specifically how the counties and cities will advertise and seek input
- All partners should be offered full partnership
- B2 should include socio-economic status
- Planning process must include formal comment period as required by Prop. 63
- Chart of other stakeholder participation – wait to let roles shake out and make sure participants are committed and committed to planning process
- Meeting must be conducive to thinking, with low noise level
- Meetings over two hours must have snacks and meal breaks
- Sessions must be long enough to be able to think through a process
- Be aware of the potential for limits in access due to ADA issues, language, transportation, venue, time of meeting, etc. Develop locally appropriate strategies to address this issue – consider using CBOs and alternate meeting strategies to address these issues
- Administrative level within county should include middle management who will input the plan, so not just involvement of leadership, consumers and providers
- Counties should justify (maybe an outcome; example: level of need for service) as to why certain stakeholders get certain levels or status)
- Process could be a burden for a smaller county
- Need a baseline of who will be involved with each population

Older Adults (12)

- AOD with older adults (2)
- Area Agencies on Aging
- Older Adult – Commission on Aging
- Aging services
- Include housing and employment for Older Adults
- Aging services networks
- Networks of geriatric providers
- Homebound adults
- Meals on Wheels
- APS
- Better definition of older adult services, i.e., include APS, ombudsperson, housing and adult day services, crisis teams, independent living groups

Issues with Attachment 1 (11)

- Concerned about the header on Attachment 1: it is arbitrary and says nothing; need to add under stakeholders, conservators, hospitals, providers (curiously missing), emergency rooms, consumers, line staff
- Attachment 1 is too rigid and inflexible
- Attachment 1 needs a column for contact information
- Attachment 1 needs revision: add more community and natural support stakeholders, especially education
- Attachment 1 is divisive, don't like the idea of categorizing; suggest instead that plans address how the broad participation will be prioritized with the consumer perspective being a "litmus test" for what is prioritized, approved
- Who defines stakeholders? Attachment 1 is a list of enforcers, of vested interests; list is not my community. Where are other non-profits, continuing education, alternative medicine, public health, recreation, exercise, spirituality?
- Attachment 1 has the flavor of agency groups and by implication, business as usual – advocates should be included in each category
- Options for stakeholders need to be expanded (more exhaustive list)
- Attachment 1: Are we trying to build a jail or transform the mental health system? We need to focus on natural supports and the larger community – need to add recreation, faith communities, education, service clubs, activities for youth, transportation, YMCA, community colleges, libraries, the UC system
- Suggest that "kept informed" and "review and/or commenter only" be deleted
- Should be more specific, but not so comprehensive that it is overly burdensome

Housing (10)

- Add housing representatives (2)
- Add shelters (2)
- Add housing in youth area
- Providing and planning for housing should be included too
- Housing needs to be added for youth and older adults
- Includes housing authorities
- Housing developers
- Landlords

Physical Health Providers (9)

- Add school-based health providers
- Include acute medical system providers
- Add medical services
- Add physical health providers
- Add physical health in youth (pediatricians)
- Add emergency room staff
- Private sector health
- Private sector hospitals and emergency rooms

- Add the word “health” included under primary care

State/County Role (7)

- In counties where there are no self-help groups, State needs to make state buildings available for public forums
- State must identify or determine stakeholders, counties must comply with or request waiver for exemption from the required participants
- Will DMH set criteria for counties regarding which groups get what status and why in terms of stakeholder input – who will get mere “delegates: or input than others – this would protect various levels of participation among stakeholders in different counties
- State must model good process and release money to include clients and families as of January 1st.
- There should be requirement that counties prepare data in support of request/proposal and identify how plan will meet outcome measures
- State should spend time defining definitions and make public to the stakeholders
- State to provide oversight and accountability to counties – State to require the counties to complete this

Law Enforcement (6)

- Add Probation under Adults
- Add Juvenile Justice
- Must include non-traditional points of entry, such as law enforcement
- Some of these agencies fit into more than one area – not sure they need to be broken into groups – just ensure appropriate representation overall. For example, Probation is youth and adults; also parole is not included
- Outreach to law enforcement

Integration (6)

- All incarcerations and social service – law enforcement agencies, medical and psychiatrist to work together to integrate
- Clubhouse model = consumers, aligned with professionals, not just consumer-run groups
- Process itself must be developed in a grassroots, participatory way, including clients, survivors, ex-patients, regardless of their level of income, literacy, fluency in English or internet access (a grassroots outreach must be conducted by consumers/survivors, to include low-income and homeless people with psychiatric disabilities, including youth, older adults, people in jails, prisons, locked IMDs, board-and-cares, and day treatment
- Information might have been disseminated better, using the paper; may have accessed more of those with need that could have contributed
- Consider who must be at the table at a minimum
- Accountability for comprehensive representation must be there

Other Representation (6)

- Outreach to rural and urban communities

- Skilled mediators/facilitators need to be present – outside consultant, neutral to come up with a goal
- Bring in IT efforts (public and private) early in planning process
- Add representative organizations that are not necessarily providing services or benefiting from the funding
- Must include a diverse group

Transportation (5)

- Add transportation agencies
- Add public transportation
- Add transportation planning groups

Form Changes (5)

- List needs to be more flexible for local planning – change chart to say “level of participation – describe”
- On form, delete box that says “stakeholder group or organization” – it’s misleading
- Add underserved or unknown or unidentified
- Add “child” to “youth/transition age”
- Strengthen footnote to meaningful involvement on page 1 of draft – more than giving and receiving input; must have a role in decision making process

Foster Children (4)

- CASA
- CWS
- Add Foster Parents under Youth

Other (14)

- The people who pay the tax are not included - they may kill the process
- Be sure the focus can stay on mental health
- Very comprehensive, thanks
- Some attention should be paid to service resistance, possibly within family stakeholders group
- Eliminate bias where appropriate
- Specifically identifiable representatives needed and named in process
- Hear from their failures, from those inadequately served, from success stories as well as failures
- Innovation prior to implementation
- Seamless system would not use these categories
- Seed money needed
- Dissemination got stuck – LMHBs, CRMHC... didn’t distribute down to grassroots
- New stakeholders to provide a different point of view – help think outside the box
- What is actually meant by comprehensive and representative?
- We believe that there are groups that are underrepresented or may not be represented here today

C. There must be clear organizational responsibility for the planning process. (75 responses)

Attachment C, Section C is discussed here

	#
All Agreed	35
Most Agreed	6
Some Agreed	2

Process (18)

- Consult with businesses and providers on how best to organize work based on outcomes
- In general, common outcomes should be arrived at or agreed upon eventually
- Affirm that this section defines who and what positions and how much time is involved
- C.3 and C.2: describe “how” the county organization – not “positions”
- Process must be centralized and representative
- Add stakeholders along with county organizations in items 1-3. Don’t limit to county organization only
- Mainstream process to make things happen
- Education around a vision statement vs. a vision document
- Have a timely yet inclusive process
- Include a timeline of each county’s process
- Counties must have a local advisory group to input into county process for planning
- A real input process must be mandated and must include an inventory of existing resources to build on
- Document changes to the planning process
- Access already accumulated community data such as CWS realignment
- Link MHSA planning process with all existing county planning processes
- Within context of exploring new, creative approaches, assess quality
- Planning needs to have a continual process in which stakeholders can provide continuing input in the planning process and refinement of programs
- When the main organizers in each county have been determined, their names should be listed on the MHSA website so people can know who to contact

County Role (12)

- Mental Health Director – an authority
- Buck stops with the Mental Health Director
- Strongly agree with this need – may need to add county staff to do this – would that be allowed?
- Each county should designate a single focal person to drive a process – require each county to do this – be specific
- County mental health must take the lead, with concern that the diversion of funding and leadership will be supplanted outside of mental health department

- Who is going to oversee is critical in setting the tone – what is process to select this person? What are their qualifications? And those qualifications should be included in this document – give criteria on who this person should be and their accountability
- Responsibilities require outside participants (other provider, contracted services) – County should be in charge of oversight, but each group has input. State DMH is subject to political pressures; program revision not mentioned
- C1-4: we are concerned this implies only the Department of Mental Health and does not include any other county programs, for example, county health department
- Counties should ensure service integration is not lost in the planning process – partner county agencies should be more than stakeholders in the journey to a system of care
- MH Directors work with leadership group to assure wide input and representation to the process
- What is the role of the Mental Health Board?
- Mental Health Board

Responsibility and Accountability (11)

- What does “who is responsible” mean? Has to be a real authority and responsibility
- Ensure that the person responsible for outreach to underserved and unserved populations reports back to the local stakeholders group
- Ensure that those with overall responsibility are directly engaged with stakeholders as identified in A & B
- Persons in charge (and the planning process itself) must comply with requirements of Prop. 63
- Those with both overall and day-to-day responsibility must proceed with transparency
- Ensure existing organizations’ responsibilities are defined
- UACC, NAMI, Client Network assume responsibility for providing county level training concerning involving under-represented families and consumers in planning process
- Utilize community-based non-profit organizations in this process as watchdogs
- Oversight and Accountability Committee include community members at local level
- Organizational flow identifying responsibilities for whom and to do what
- Organizational responsibility needs to be more clearly defined

Consultants (6)

- There is already a cadre of consultants that could be used – make these resources available (i.e., DMH/DR Coop trainers) and train on how to access them
- Concern for #4 – consultants – used for content and process – diversion does not make sense
- Consultants that are hired must be through an open bid process with stakeholder input
- Hire independent consultant to facilitate planning process
- Ensure the independent consultant is organizationally linked to a county official responsible for final plan

- Explore possibility of outside facilitators in process, initially full-time

State Role (6)

- Break it up by regions and then counties to find specific needs
- Forms should give guidance to the counties
- State DMH needs to clarify how the county DMH will engage other county agencies
- State level must develop accountability mechanism to ensure broad stakeholder involvement
- Each county be assigned a “key” person at DMH
- State hold counties accountable

Consumer Roles (6)

- Family and clients have responsible positions; how many and what positions
- Have a non-county employed consumer position placed on the planning board
- Concerned that state-mandated consumers have decision making authority in all levels in all counties
- We should have at least 50% consumers make the decisions in the process (a part of the governing body in this process)
- Funded family member roles – family liaison office (for example) and consumer
- Certify percentage of time family members of children will devote to the planning process

Other (16)

- Looks OK
- Consider adding compensation to stakeholders
- #4 – don’t need
- AOD – include all internal and external mental health sources
- Infusion of money upfront
- Allocate some money to policy reform
- Funding issue not enough – how is it divided?
- C3: please expand to include providers
- In area of prevention and early intervention, must be charged to area experts on prevention and early intervention
- Include percent of time under 3 and 4, like 1 and 2
- Other service organizations
- Various challenges in each county
- Planning should have objectivity for a good plan
- Ensure you look at how sustainability will be ensured
- Need seamless integrated system
- Think in non-traditional system ways

**D. Planning process must be adequately staffed to be successful and inclusive.
(81 responses)**

Attachment C, Section D is discussed here

	#
All Agreed	30
Most Agreed	8
Some Agreed	2

Staff Knowledge and Skills (17)

- Staff must also have knowledge of co-occurring disorders, including developmental or cognitive issues
- Staff must have knowledge of and ability to conduct planning and to implement plans
- Staff must have knowledge of needs and resources in the community
- Under D.8, add gender differences (women/men sensitivity)
- Under D.9, add veterans issues (women/men sensitivity)
- Add senior/older adults separately
- Add knowledge of local community
- Add knowledge of issues related to dementia in older adults
- Prevention and early intervention must be staffed by a person with this specific expertise and who has experience working with community-based providers such as community clinics and health centers
- Preference for hiring those with consumer experience in each of these categories
- Add “knowledge of Evidence Based Practices” to the knowledge base requirement
- Should make mention of fiscal expertise
- Should make mention of evaluation expertise
- On narrative, add “knowledge of importance of consumer, family and community involvement”
- In top paragraph, add 4.) the team as a whole should be knowledgeable of all areas listed on Attachment 1, not just those in 1, 2 and 3. They need technical knowledge of the systems and how they work. Temporary staff should have knowledge of stakeholder issues/needs
- Diverse cultures and populations
- Individuals with expertise in program efficiency and humane methods

Stakeholders (10)

- Add older adults
- Add to D.4-7 – which includes advocates, community leaders, and staff serving such underserved populations
- Add researchers and affiliations
- Direct service staff need to be involved in this process to get buy-in
- Need to add another stakeholder – 8. service providers, especially those outside the county system
- Private sector should be included
- Include treatment providers or community-based providers in list
- Educational representatives

- Representation should include ethnic and cultural representation
- Include all stakeholders, i.e., judicial system
- Specifically include community-based organizations

Consumer Roles (7)

- Yes, most definitely with a lot of mental health consumers involved
- Include family members of older adults
- Knowledge from consumer-provider training program must be valued and acknowledged in this process
- Put consumers on the top of this list – need to include consumer trainers and consumer planning consultants
- Consumers and families, consumer advocates and providers 1-7 should be paid plus community-based organizations should be paid and involved
- 50% should include consumer in the process
- Paid consumer positions to reach out and impart knowledge

Resources (7)

- Build on other ongoing processes
- Counties should rely on statewide family and consumer organizations to assist them in training local family members and in creation of tools (VAC, NAMI, Client Network)
- Agencies could provide employees “on loan” to fill these development needs (to avoid extensive hiring costs)
- Reword last sentence “Indicate which...” with “ensure that the following positions are filled with individuals from the stakeholder list when possible”
- Need to support other community partners with planning funds or make counties accountable for using funds to involve them in a meaningful way
- County may apply for county funding or for private groups to provide planning services for the county. Private groups meaning, community-based organizations
- Include community support systems, i.e., local businesses, child care providers

Barriers/Issues (7)

- There are doubts whether 1-3 of the staffing principles can be attained – the way it is written, it seems it is all or nothing in terms of success
- Express limits of staffing here – important for small counties
- Given recent cuts in public mental health funding, will they be staffed to really get full input?
- Does not sound transformational
- Not relevant to small counties with no resources
- Continuity of information during staffing changes
- How to correct or revise planning especially with regards to successful outcomes vs. failed outcomes – vision to plan to implement to measure to change – need personnel for these evaluations

Training (5)

- How can these people be trained and how fast?
- The training must be a mixture of consumers, providers and professionals
- Develop tandem mentoring process for ongoing planning
- Training is extremely important initially
- Help people to gain the knowledge needed

Consultants/Technical Assistance (5)

- In order to adequately change the system, we need to broaden our thinking and move outside our current delivery system – use technical assistance to address this issue
- Fear that consultants might end up taking over
- Consultants should be selected through an open bid process with stakeholder input
- Smaller counties may need outside technical assistance or pool resources
- Planning/financial consultants

Funding (4)

- If not clear, administrative costs should be capped
- Questions how to do this if folks don't know how much they have to spend
- Compensation for volunteers with mental health expertise
- Concern that not enough cash is allocated up front – need to frontload and support this planning process

Other Staff Qualifications (3)

- Under 7, the word “expert” should be plural experts – there should be more than one racial ethnic disparities expert
- Do not limit new staff hired to those with a background in mental health – clerical staff for example
- Accessibility to different language capabilities (include ASL)

Other (15)

- Proposals should not just provide lists, but should describe the skills and include a narrative on background of each person involved
- Make it as strong as possible
- Meaningful inclusion of staff
- May need to add a category for administrative support – county hired lead staff
- The team used for planning and implementation needs to be continued for program evaluation
- 2a) add at end after MHSA “and the local county Mental Health budget.”
- 2b) add such as peer support and self-determination
- What about community partners who will not be paid for their planning participation?
- Doesn't talk about process
- Appropriate staff, not adequate staff
- First determine the need, then determine how to appropriately staff
- Add comment that says “must be inclusive for a successful outcome”

- In first sentence, add planning or work before activities
- Is hiring staff for preparation of plan necessary and are they adequately trained and in line with vision statement
- Have multilingual forums in their communities

E. Full participation requires adequate training in advance. (92 responses)

Attachment C, Section E is discussed here

	#
All Agreed	30
Most Agreed	5
Some Agreed	4

Training Target Population (25)

Mental Health Providers (7)

- Line staff should be included (2)
- Add providers to other stakeholder training
- Mental health professional workers, physicians, social workers, professional workers, recreation therapists
- E1: include training for residential providers, mental health housing specialists and employers
- E1. include primary care providers and others who provide mental health services
- Training of mental health professionals with developmentally disabled population

Consumers (5)

- Affirm the effort to train consumers to participate
- Consumers need training on systems changes to assist them in giving ideas on making improvements
- Need training for underserved communities
- Families need to be trained as well
- Add category for training consumer-providers and how they can advance in their careers

School Staff (5)

- Add to training: e) PPS service providers (school counselors, school psychologists and school social workers) and others in schools that service students with mental health needs (i.e., nurses CWA) (2)
- Include K-12 special education and general education in the process – they are currently excluded
- Add school staff, counselors, school psychologists and nurses for training
- Include school health staff

Others (8)

- Beginning at the high school level and up
- Community (forums) members
- Add medical personnel who would be part of implementation plans

- Make sure there are trainings meant for “new staff” because of turnover
- Add stakeholder non-profit housing alliances for training
- Add midlevel management
- Add support staff
- Add public health, drug and alcohol, and primary care

Training Topics (21)

Content Training (12)

- Add Evidence Based Practice: best practices for and outcomes of standards of care
- Peer counseling training (peer to peer)
- Ensure education on proposal development and outcome measurement
- Add foster care, youth, AOD and CDSS
- Add content concerning impact of dementia on all aspects of care
- Include training of integrated mental health in primary care settings early as a system change
- Training for accessing the system
- Community training to understand mental illness
- 2C – addressing and defining underserved and unserved population
- 2a. training in Crossing the Quality Chasm, Achieving the Promise

Process Training (5)

- Train people on how to participate in the planning process, including assisting consumers in effectively expressing their views, values and needs
- Train on how to facilitate meeting and how to make decisions
- Work on consensus building
- Club house training – attitudinal training
- E2e. More than system change, we need training about transforming the system including values and model programs

Diversity Training (4)

- Cultural competence should be listed as a category by itself to indicate commitment
- Add training on diversity and trauma
- Add women/men sensitivity with gender differences and veterans issues
- Seems comprehensive enough – needs to provide training across the life span

Training Issues (13)

- Some training may slant being objective and could be costly and slow down process
- Add elements to E.2) g. stigma
- Add barrier to full training
- E3 Funding – describe potential barriers
- Training should not drive the agenda but should be used to build capacity, i.e., train to what is an evidence-based program and what does it mean to be outcome-driven. Once this training is completed and you have built capacity to understand this concept, they you can provide a menu of evidence-based programs
- Must have good public relations

- Bilingual (centralize for cost efficiency) training materials
- Language competencies
- Training appropriate to audience
- One size does not fit all
- Possible technical difficulties to hire for planning ahead of time without a county-approved plan
- More communication among services, i.e., DDS, DMH

Trainers/Training Staff (8)

- Suggest technical assistance contractor for state to insure quality and really create system change
- Who will translate for diverse groups?
- Need to identify resource person for trainings
- Create a statewide training council or pool to ensure that training is coordinated and demonstrates MHSa principles. For example, council would include UACC, NAMI, CIMH and Client Network
- Broad-based training that is not academic only – consumer organizers
- Training to include training from others like law enforcement
- Training should be focused on a paradigm shift with clients training professionals, especially in relationship to the recovery model
- Draw upon experts who can facilitate the transformation of change

Training Timing (7)

- Training must be an ongoing process
- Add in advance and concurrently
- May need flexibility to train and get input at same time – may not be able to train all first, then plan to plan
- Training in advance – people need financial support to attend training, such as consumers from all counties need funding to attend the MHSa training at the CNMHC Forum
- What does “in advance” mean?
- Training needs to occur as we put together the plan

Definitions (6)

- Should be appropriate training, not adequate
- Specify “adequate training” with timeframe in order not to delay the process!
- Define “adequate”
- Define “full participation”
- What is the definition of training (i.e., education, expertise) and who and what topics would this include?
- Clarify what the training is for

State Role (4)

- State should come up with template that counties could modify
- What role does State have in providing training?

- Responsibility of state with local county stakeholders' input
- State should create RFP process for training contracts as compared to just increasing contracts of current training organizations

Other (8)

- Racial ethnic disparities expert should be plural experts, as one person cannot know about all diversity
- Start evaluation process at beginning
- Mainstream rather than group people in large centers
- Add glossary of terms and make it simple – use common language and understanding
- Equal pay for consumer-providers and other line staff
- Include payment for private sector for training
- Reinforce training as an ongoing principle for each component of MHSA
- Ideally this is the case, but the reality is this may not occur

F. Proposed Workplan (81 responses)

G. Proposed Budget

Attachment C, Sections F and G are discussed here. Please note they were discussed together, so the number of responses are noted under F above.

	#
All Agreed	25
Most Agreed	5
Some Agreed	0
Disagreed	1

The proposed drafts provide little detail in these two sections. As DMH develops these two sections further, what are critical components of the workplan and budget that every county should submit.

Budget Categories (25)

- Budget for housing, including supported housing
- Budget should be by component
- Budget must include transportation
- More educational outings
- Under capital facilities, add bullet point support services, offices and facilities
- Funding to develop support system
- Planning stakeholders should be given money to provide the infrastructure for giving data, i.e., schools have the data but may not have the staff to generate the information
- Provide stipends to consumers and family members who are appointed to county planning committees
- Consider including media

- Would like to see consultant costs be held to a certain percentage, like 50%, to guarantee there is money for consumer involvement, outreach, etc.
- Budget should show subcontracts to other critical stakeholders outside the county system
- Travel – meeting costs for public/community forums
- RFPs
- Research
- Training
- Equipment
- Data Collection
- Staffing
- IT
- More money for mental health staff and client ratio
- Build up mental health program – get a full time psychiatrist to replace part time ones
- Should definitely put the money toward mental health
- Include mentally ill homeless in their budget calculations

Workplan (18)

- Detailed by flexible workplan
- Formalize agreements (MOUs) with partners for their role in workplan
- Look at older adults (anyone for that matter) with mental health issues as well as medical problems
- Readiness
- Make sure different cultural groups have access and make sure money is there to support consumer involvement
- Inventory of existing mental health delivery system including services outside the county system and how the plan will build on this system
- Shared training with all stakeholders
- Standardized service components as a floor to built upon to address inter-county issues
- Investigation of best replicable practices that will be incorporated at county level
- Evidence of stakeholder participation
- More education for the public to let them know we are not monsters
- A communication plan should be one of the necessary components
- Marketing – newspapers, websites, videos, radio
- Use commercial media to attract community members - PSAs
- Can we have open hearings in front of local Mental Health Board? What is proposed?
- Time and dollars for utilization review and quality assurance functions
- Determined by time line and budget
- Add achievable outcomes – performance should help dictate future allocations

Budget Issues (16)

- Should have a simple, common format for all counties

- Cap administrative costs
- Utilize existing service providers and consult with them to expand services
- Compensate individuals to attend Consumer Training sessions
- Must have clarity on current budget and current program funding in order to identify new programs
- Designate funds so they don't get diverted
- Put state-determined parameters around spending in component areas
- Back-up plans – contingency plans for budget
- Re: Attachment E: There needs to be another methodology to capture people who are not in the system and receiving services
- Re Attachment E: Why is planning money different in each county? Wouldn't the basic cost of planning be about the same?
- How soon is the money going to be used for services rather than planning?
- We have real doubts about the allocation methodology
- Realistic budget
- Prepare 1, 2 and 5 year financial plans
- How does this plan get integrated into the existing plan?
- Involvement of how this will pull in other state and federal resources

State Role (5)

- DMH review, including stakeholders to evaluate plan and ensure accountability and meaningful involvement
- Make sure funding is timely
- Human Resources development of qualified mental health requires state level responsibilities as well as county
- State needs to publish guidelines for review and comment, followed by further review and comment of county plans

Timeline (4)

- Create clear start and end dates for county planning
- Include timeline
- Give guidance for realistic timelines
- Need to include timelines, especially for community outreach – for example, when will information be available for review, and when will input be required

Consumers (3)

- Client run services will need assistance and training in running programs and financial budgeting and development and administration of programs
- Emphasize hiring consumers – realize this could be a problem for smaller counties – encourage regional collaboration
- Accountability for outcomes and to consumers (see Prop. 63 section 5848(c))

Other (10)

- Did not have time to discuss
- Draft is not comprehensive and requires more time to discuss

- Proposed budget is not included
- Instructions need to be written by a journalist
- Can't be a cookie cutter, needs opportunity for uniqueness of counties
- What about community partners who will not be paid for their planning participation?
- What are options for stakeholders who are not receiving funding – and what do they do if they feel plan doesn't reflect their needs?
- Much more detail but to be developed over time
- Make it easier for small counties to start mental health programs
- Who is going to do it?

Other Comments (5)

- Carol and Marilynn did a great job
- Add evaluation component
- Definitions should be determined throughout and made public
- Yes, fund right away provided these stipulations:
 - The initial funding should be only for bringing in more consumers, families and community-based support agencies into the planning processes, especially among the underserved populations
 - Funding should meet these requirements in each county:
 - Transportation to get there and home (bus fares, carpools, van pools, etc.)
 - Meals at meetings
 - Child care for parents attending meetings
 - Lodging for long distance or lengthy conferences
 - Stipends for consumers to attend so they can advocate
 - Computers at self-help centers and regional transit centers so clients can cross the “digital divide” – allocate priority computer use for consumer advocacy work