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HEALTH SERVICES

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CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION
MHC/CPAW Capital Facilities Workgroup
Monday • October 19, 2009 • 6:15-8:15.m.
MHCC Central County Wellness & Recovery Center • 2975 Treat Blvd., Bldg. C • Concord

The Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings who contact the Executive Assistant at least 48 hrs. prior to the meeting at 925-957-5140.

AGENDA

Public Comment on items listed on the Agenda will be taken when the item is discussed.

1. 6:15 **CALL TO ORDER / INTRODUCTIONS**

2. 6:20 **PUBLIC COMMENT.** ***[First 5 Submitted]***
The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant.

3. 6:25 **ANNOUNCEMENTS**

4. 6:30 **APPROVAL OF THE MINUTES**
ACTION October 5, 2009 MHC/CPAW Capital Facilities Workgroup meeting

5. 6:40 **CHAIR COMMENTS**:
A. Report on MHC 10/8/09 meeting (refer to DRAFT Minutes from that meeting). Share public comments heard at Mental Health Commission Meeting. Refer to letter received from the Diablo Valley Family Coalition.
B. Invite new attendees (Workgroup members only) to state their personal goals for the outcome of this process.
C. Report any developments discussed at 10/15/09 CPAW meeting.
ACTION D. Discuss ways to inform workgroup members, on previous efforts, without reviewing at each meeting. Brainstorm on data compilation and links to previous meetings and documents. Seek ways to inform the workgroup and the public, through a Lean process, that would assist the timeline requests.

6. 7:00 **QUESTIONNAIRE/SURVEY DRAFT** – Sherry Bradley, Susan Medlin

A. Hear Report and recommendations from Steve-Hahn Smith on survey process and IT data and information.

ACTION B. Questionnaire/Survey Draft: Review, discuss and make final recommendation

7. 7:35 **Establish Benchmark Timeline for Overall Process.**

ACTION A. Set goals for a timeline that would establish incremental progress demonstrating the value of the process to the public and the Health Services Department.

8. 7:55 **REPORT INFORMATION ON ANY NEW PROPOSALS FROM STAKEHOLDERS.**

A. Children's Proposal and Older Adult Proposal-Kathi McLaughlin.

B. Hear from other attendees on suggested use of Capital Facility Funds.

9. 8:05 **NEXT STEPS/SET NEXT MEETING DATE**

10. 8:10 **PUBLIC COMMENT.** ***[Remaining]***

The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant.

11. 8:15 **ADJOURN MEETING**

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 72 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours

MHC/CPAW Capital Facilities Workgroup Meeting

Date: October 5, 2009, 6:30-8:30 p.m.
Location: Mental Health Consumer Concerns (MHCC)
2975 Treat Blvd., Bldg. C, Concord, CA 94518

Minutes – Draft

1. CALL TO ORDER/INTRODUCTIONS

The Workgroup meeting was called to order at 6:30 p.m. by Chairperson Teresa Pasquini.

Mental Health Commissioners Present:
Dave Kahler, District IV
Anne Reed, District II
Annis Pereyra, District II
Teresa Pasquini, District I – Chair

Attendees:
Sherry Bradley, CCMH
Karen Shuler, MHSA Communication Coordinator
Steven Marks, MHCC
Ryan Nestman, Consumer/Family Member
Cindy Staten, MHCC

Consolidated Planning Advisory Workgroup Members Present:
Brenda Crawford, CPAW
Susan Medlin, CPAW
Tony Sanders, CPAW

Absent: MH Commissioner Colette O'Keeffe
CPAW Member Kathi McLaughlin

2. PUBLIC COMMENT

Speaking as a member of the public, Mental Health Commissioner Dave Kahler distributed a memo to the Workgroup that outlined his concerns. He stated he wants to see an assertive timeline developed that would acommodate the pressures for using the 20 Allen site. He said it is the only property contiguous with the hospital and may be assigned to someone else if the timeline is not assertive. As a Commissioner, he said he would like to have the opportunity to vote on it before the December 31st deadline for acquiring the property.

3. ANNOUNCEMENTS

Teresa viewed "Minds on Edge" on PBS and found it riveting. It will be on TV again and is also available on the internet.

4. APPROVE OF THE MINUTES

- **ACTION: A motion was made by Annis Pereyra and seconded by Brenda Crawford to approve the Minutes from the September 24, 2009 MHC/CPAW Capital Facilities Workgroup meeting. Tony questioned the costs of electronic records and the percentages as stated in the Minutes. He asked if the breakdown will be on this or a future agenda. Teresa said it would be covered on this agenda. The Minutes were approved as presented.**

5. CHAIR COMMENTS

A. Discuss any procedural concerns for future meetings. Report on conversation with Dorothy Sansoe.
Because of confusion over the meeting process, Teresa met with Senior Deputy CAO Dorothy Sansoe. Teresa explained that the Mental Health Commission has been meeting in workgroups over the past year, and no noticing is required so long as a quorum is not present. But in order to get the information out to as many people as possible, Teresa stated she would like all future meetings to be noticed, if possible. There was

discussion as to having meetings on set days. Teresa said she would like more clarification regarding the Brown Act requirements.

- **Recommendation: Anne suggested taking the matter of noticing the meeting to the full Commission for a final decision. There was consensus on taking this matter to the Commission.**

B. Discuss and agree on reporting procedure to MHC and CPAW.
Teresa wants this group to make the decision as to how to report back to the MHC and to CPAW. Ryan suggested that one person would make the report to both groups. Who would be eligible to give the report was discussed. Concern over conflict of interest and maintaining a balance was expressed. Brenda suggested that a CPAW member report to CPAW (Brenda volunteered) and that a Commissioner report to the MHC. Annis suggested having a collaborative effort between a Commissioner and a CPAW member.

- **ACTION: Anne made a motion that Brenda, Ryan and Annis work together to compile a report to the MHC and CPAW and present it each month. Annis seconded the motion. Motion passed unanimously.**

- **Recommendation: Brenda, Ryan and Annis will work together to compile a report to the MHC and CPAW and present it each month. The Workgroup's Minutes will go out to both the MHC and CPAW.**

C. Invite new attendees to state their personal goals for the outcome of this process.
Tony Sanders: To ensure that as many stakeholders as possible are included in the process. Groups have been identified as being underserved, and would I like to take that into consideration.
Ryan Nestman: It's about knowledge for me – and finding resources for my family and me.
Anne Reed: I want to be part of this workgroup to ensure we don't miss opportunities to create the type of services that will improve life for the consumers.

D. Report any developments discussed at 10/1/09 CPAW.
None were reported.

6. QUESTIONNAIRE/SURVEY DRAFT

A. Background to the Questionnaire: Review, discuss and make final recommendation to be presented to MHC on 10/8/09.
We wanted the Questionnaire to be in a language people could relate to, and not just showing gaps in the services assessment, but one showing what could be done with Capital Facilities Funds. Note: Discussion of the Background to the Questionnaire immediately flowed into a discussion that included suggestions, concerns, objections and recommendations (listed in B.)

B. Questionnaire/Survey Draft: Review, Discuss and make final recommendations to be presented to MHC on 10/8/09
Questions/Suggestions:

- Tony asked where stakeholder groups that have been surveyed would be listed?
- Teresa said the information is included in the data compilation. This process was about getting new data and this would address anything new that has come up.
- Susan suggested listing "additional interests" under #1 ("My experience with Contra Costa Mental Health is based on:")
- Annis suggested placing "previous stakeholder participation" under #1("My experience...")
- Sherry said a suggestion had been made to add "Check all that apply" to each question.
- Tony suggested adding the best practices categories under "Gender".
- A suggestion was made to add "Sexual orientation" under "Gender" and above "Age"
- It was decided it would be a good idea to check with the specific State listings and with Human Resources to see how to correctly list items regarding gender.
- Anne suggested not just using the word "Other".

- Anne said there was no indication of polling for economic or location information.
- Brenda stated we are looking to get a basic snapshot of what had changed over the 5-year period since the previous surveys. What services are needed now so far as Capital Facilities is concerned -- how should this money be used – are there any new ideas? She wanted the focus on where the services should be located.

After discovering duplicated numbers on the Questionnaire that confused the review process, it was decided to refer to an updated copy of the Needs Assessment Survey, Sherry distributed corrected copies (with tracking changes).

- Annis asked to remove the "Restrictive settings" bullet (second to last bullet under "How should an MHSA funded Capital Facility be used?")
- Under the same category, it was suggested that The Clubhouse be added as a bullet.
- Under the same category, it was suggested changing "co-occurring" to "dual diagnosis"
- Add "mental health and other integrated services"
- Add "psychiatric recovery centers"
- Pull out mental health and substance abuse -- separate dual diagnosis – it could include counseling
- Instead of using the acronym "TAY", say "Young adults"
- Anne Reed said the information is too specific. It needs to be information that has value.
- Susan expressed the opinion that most consumers would not fill it out.
- The group as a whole liked Question #4 – "Which of the following needs, identified in MHSA planning processes, community forums, focus groups, do you feel are most important?" It was felt that we have to rank it to give it value.
- Anne said make #1 ("How should an MHSA funded Capital Facility be used"): "If you had the money to build a building for mental health services, rank these in the order you would put them."
- Teresa referred to the component Exhibit 3, saying it answers the Charge given to the Workgroup at the 9/3/09 CPAW meeting. It gave us an idea of what we were going to end up with. We need to review the answers and alternatives. Now we need to find the IT needs.
- In asking for suggestions, it needs to be clear we cannot include housing.
- Step 1: The questionnaire will address what we want
  Step 2: What we can have.
- Ryan suggested referring people to the website for more detailed answers.
- Sherry said the research suggested we should ask people to join a focus group to give and get more information
- Teresa said that as a group we decided we would not be dictated by an arbitrary time, meaning the 12/31/09 deadline was not going to run the show. This could be changed at the MHC meeting.
- Annis suggested sending out the Questionnaire and set up focus groups so the dates would already be set.
- Tony suggested placing on the Questionnaire ideas that have already been suggested, and tell what the money could be used for.
- Susan said she wants to make sure each individual client is reached.
- Brenda said one of the reasons we're doing this is there's a perceived/or in reality notion the community was not reached out to. 20 Allen St. proposal was presented, but not other alternatives. She said we need to have a realistic time frame. How can we meet needs we say were not met previously without going into an in-depth procedure, thus costing more money.
- Back to the Questionnaire, Susan said, we need to define "Crisis Residential Center". She suggested "Voluntary alternatives to hospitalization"
- Teresa said we just need to make an effort to reach as many as people as possible.

Sherry said she will copy summaries of all focus groups and community forums. Information will show if this where we still are today. Needs listed were:

- Housing
- Education

- Societal development
- Transportation

- Brenda said we need to integrate the focus groups into the process.
- Anne stated that we need to come to a general agreement about the survey and get it out and going
- The opinion was restated that it needs to be written in common language
- Anne stated that she can support the decision not to be driven by the 12/31 deadline so long as everyone understands that at some point they will look for someone else to buy the 20 Allen St. site.
- It was asked how this survey helps us get to that process.
- Teresa said that this was our goal to do this...to try a questionnaire.
- Tony added the questionnaire was to include categories of types of facilities.
- Brenda said that the way 20 Allen St. unfolded was a concern – its being centralized in Martinez – was this the best use of this money? So we started thinking about developing services in other parts of the county. Do we want to put it all in this 1 location -- what is the impact on other parts of the county? Is this the best model? The feeling is that it wasn't a participatory process.
- Annis asked if there was a way to provide these services at areas throughout the county?
- Susan said it needs to be near the hospital.
- Teresa said she thinks there could be regional crisis centers.
- Annis said there are other models -- such as Kaisers call center that diverts people to a crisis center nearest to them -- why not have a 24/7 call center with response teams throughout the county, in conjunction with CBO's.
- Ryan asked why not a mobile crisis center in every region?
- Mark mentioned that a lot of people need to get away from their home and a lot of them need to get away for a few days.
- Anne said the agenda item is to discuss the survey and whether the survey meets the needs.
- Brenda said it needs to combine questions and ask the people to prioritize what is needed – and give examples.
- Teresa said we're not necessarily meeting the expectation of what we were trying to accomplish here.
- Anne said a question should be, if given the money, would you want it in central county, decentralized, don't care, or just want the services.
- Current and/or future accessibility needs to be taken into consideration.
- Teresa added: what does the community need -- we need accurate, scientific data. Finances will come into the decision-making.
- Anne asked if this Questionnaire will substantially enhance the information we already have?
  The overall consensus was No, but there was a feeling a simple survey needs to be done.
- Anne said part of our responsibility is to draw upon our own experiences, data collected, and the experience of others to make a decision.
- Teresa said she was never shown the information as to why the money was going to be spent for the PHF to be built. She said she wants something to make sense.
- Brenda said we also need to give folks in the community alternative models. We need to talk about the broad spectrum of options on a survey, and give people the range of choices that are out there. She stated she wants to decrease the number of involuntary commitments into county hospital. She added that we need to develop a Questionnaire that gives a range of options with a place to write.
- Anne mentioned the need for each option to be economically about the same.
- Brenda said we need to pull out of 20 Allen St. proposal the amount that would be funded by MHSA and show that number.

There was discussion about IT and the expense of getting the medical records computer system up and running.

- Annis said that a combination of Capital Facilities/IT and innovation is $10.2 million. She asked if the money

can come from the county to augment the $2 million IT money.

- Sherry said the County is looking at more options.
- Tony suggested taking the survey and before the next meeting each work on the range of options and include it.
- Brenda said we need to ask what would they like to be developed in the way of services
- Teresa said that was her goal – to ask what are our needs?
- Sherry said we should include IT in the choice of options.

➢ **ACTION: Anne made a motion to table any decision and take no action on action items A and B with regards to the presentation of any final recommendations to the Mental Health Commission on October 8th. Teresa Pasquini seconded the motion. It was thought to be an excellent idea. The motion carried unanimously. Following further discussion, it was decided to ask that the motion be withdrawn. All who had voted to accept the motion agreed. Anne withdrew the motion.**

Teresa mentioned that the MHC will not be able to hear anything until November 12th, although a Special MHC Meeting could be called. Tony recommended asking the MHC to request a range of options.

➢ **ACTION: Anne made a new motion that we incorporate the changes that Sherry has written, create a new draft of the questions and present the draft to the MHC with the proviso there will be one question yet to be formulated dealing with the range of possible options. The motion was seconded by Annis. Motion carried unanimously.**

➢ ***Recommendation: We incorporate the changes that Sherry has written, create a new draft of the questions and present the draft to the MHC with the proviso there will be one question yet to be formulated dealing with the range of possible options.***

7. POSSIBLE DATA SOURCE DOCUMENTS

A. Review and Discuss.
No discussion.

8. INFORMATION ON CHILDREN'S PROPOSAL

A. Discussion.
No discussion.

9. NEXT STEPS/SET NEXT MEETING DATE

- **Next meeting date: Monday, October 19th at MHCC from 6:15-8:15 pm**
- Members each bring their suggestions for the survey to the next meeting and we discuss and come up with a final decision.
- Tony suggested having a presentation by IT representatives.
- Sherry will send out a chart of data resources for PEI, CSS, WET, Housing, Innovation, etc.

10. PUBLIC COMMENT

None.

11. ADJOURN MEETING

The meeting was adjourned at 8:45 p.m. by Chairperson Pasquini.

9. MHC COMMITTEE/WORKGROUP REPORTS

A. At the 9/3/09 Special Meeting, the MHC voted to join with CPAW to form the MHC-CPAW Capital Facilites Workgroup, including 4 assigned CPAW members and 4 MHC commissioners (Vice Chair Pasquini and Commissioners O'Keeffe, Pererya and Reed) They have had 2 meetings, 9/24/09 and 10/5/09. Commissioners Honegger resigned as Chair of the workgroup and Chair Mantas requested Vice Chair Pasquini take over as Chair. The minutes from both meetings are in the packet. At the first meeting they agreed on the charge for the group, including reviewing alternatives and options, including the 20 Allen site, and IT needs. The Workgroup added back in the IT funds which had been taken off the table, but but the Workgroup wasn't aware of that. Sherry Bradley stated that removal of funds had taken place prior to CPAW being formed. The consensus of the group was that they didn't want to be driven by a timeline; the want to process to be done properly and include a needs and priority analysis in order to determine what the actual county needs are. As was presented at the 9/3/09 Special Meeting, other counties have developed priority lists including up to 10 items and Contra Costa County had only 1: the PHF. The commission voted and the workgroup agreed further analysis was needed to determine if that single option was the best use of the funds.

Commissioner Pereyra wanted to make sure it was clear the Capital Facilites and IT funds were in one pot of funds. The Workgroup was told the computerized medical records part of the project, originally thought to be $2 million, has come in at $5-6 million. Sherry Bradley said that amount includes electronic medical records system, personal health record system and e-prescribing. Vice Chair Pasquini asked if there would be any future MHSA funding that could be allocated for that type of project? Sherry Bradley said no. If the funds were not used for IT at this point, the opportunity is lost unless the County wishes to fund it.

Vice Chair Pasquini said the Workgroup decided the needs analysis survey questionnaire presented at the10/5/09 meeting did not accomplish what they were looking for and was to be revised. Based on the meeting minutes, Sherry Bradley revised the survey, but it's missing an IT question.

Vice Chair Pasquini said there is community interest in a timeline and although the Workgroup doesn't want to be driven by one, they understand the need to establish a timeline. The Workgroup is looking for ratification of the work they have agreed to and permission to move forward per the directive at the 9/3/09 Special Meeting.

Commissioner Reed stated that although the Workgroup doesn't want to be driven by a deadline, everyone understands they don't want to delay to the extent that it might foreclose any options. There is a general sense of a lack of data of the true needs and desires of our consumers are and that's the reason the Workgroup came up with a "down and dirty" survey that can be sent out to an extensive group of people quickly and the data returned to determine if the option on the table (20 Allen site) is the best meeting the needs of consumers and family members or whether there are other options that need to be explored. They are hoping the survey will provide the data they feel is currently lacking.

The Workgroup is moving as quickly as they can. Meetings are public and if a timeline is important, meetings may go to once a week and not be posted according to the Brown Act and Better Governance Ordinance requirements. Dorothy Sansoe reminded everyone the meetings can still be noticed, but just not meeting the time requirements. Vice Chair Pasquini wants to reinforce the Workgroup wants to be inclusive and thorough; not about what she wants as a commissioner, but what the county consumer needs.

ACTION: Motion to authorize the Capital Facility Workgroup to create and send out a survey, to expedite it, to poll the community on the Needs Assessment Survey for Capital Facilities Funding. It would be in some form similar to this survey discussed today. (M-Pereyra/S-Overby/P-Unanimously 7-0) (Commissioner Kahler left the meeting prior to this agenda item and did not participate in the vote.)

Discussion:
Commissioner Yoshioka wondered if expert consultants would utilized in preparation of the survey or if the Commission has had pervious experience to conduct the survey. Does the Commission have the experience to develop a survey? Sherry Bradley said MHA is committed to providing the support the Workgroup requires. She submitted the survey to the Planning and Evaluation Unit (research unit) and they've given some suggestions that were included on the draft survey. After revisions are made, the Planning and Evaluation Unit will review the survey once more. Commissioner Yoshioka wondered if the survey would be tested prior to issuance; Sherry Bradley said no.

Vice Chair Pasquini mentioned she did not believe the County did testing analysis on the original proposal. Suzanne Tavano concurred. Vice Chair believes this survey will be an acceptable tool to gather this type of material.

Mariana Moore voiced her serious concern that people may not understand what the options mean on the first page. It might be good to have some consumers fill out and test the survey. Vice Chair Pasquini mentioned we have several consumers on the MHC and Brenda Crawford offered to have consumers test the survey at the West, Central and East County centers. Sherry Bradley mentioned the Planning and Evaluation Unit suggested testing the survey as well. Mariana Moore suggested having a definitions page included in the survey. Vice Chair Pasquini mentioned she wants to make sure consumers are able to participate since that was a missing piece of the original process.

Suzanne Tavano would the survey results be balanced against data based on usage? There are "wants", but they should be balanced against actual utilization information. Commissioner Reed stated the survey would be one source of data used in conjunction with others.

Commissioner Yoshioka asked if the Research Unit would be able to provide information about how PHFs are doing in terms of best practices within the counties that have county hospitals? He looked at Alameda County's website and found out their PHF is located 12 miles away from Highland Hospital. He wants to make sure we have access to all information on best practices and we not missing information available from other counties. Having a survey is one avenue to

pursue, but we should identify best practices from within California counties that have these types of facilities as well.

Teresa (from ?) Commented we need to be cognizant about length of stay at a PHF and the program options that might be available. There are several PHFs with the Crestwood system and the stays are quick. Long term, getting people enrolled in programs and out in the community, it's a quick turn around. She encouraged everyone to look at practices that are high impact and quick. Vice Chair Pasquini recommended everyone read all the documentation the MHC has produced over the past year including the efforts to seek information and analyze it.

Commissioner Reed reminded the group that the motion on the floor is to ratify the Capital Facilites Workgroup intent to send out a survey. Anyone with comments regarding data collection can attend the next MHC-CPAW Capital Facilities Workroup meeting on 10/19/09 at 6:15 pm at Mental Health Consumer Concerns facility.

TO: Contra Costa County Mental Health Commission October 7, 2009
cc: Contra Costa County Board of Supervisors
cc: Contra Costa County NAMI Board of Directors

This letter comes to you from a formalized group of concerned families (The Diablo Valley *Family Coalition*) regarding the current Contra Costa County Psychiatric Health Facility (PHF) proposal.

Our statement to the Mental Health Commission:

- We (family members) have reviewed and provided comments on the PHF plan at the public hearings and forums made available to us
- We approve of the PHF plan as proposed at this time
- It is imperative that the existing 23 beds on Ward 4C remain open

Our formal request to the Mental Health Commission:

- Vote today to request that the county earmark the land on Allen Street for mental health care system use while you complete your research and inform the Board of Supervisors of your decision
- Approve this project as proposed at this time
- Do not waste funds or time on assessing alternatives, rather use that money and time to address citizens concerns regarding accessibility of this site (e.g. ride vouchers or similar fiscally sound solution/s), etc.
- Set an assertive deadline to move this project forward so that this opportunity is not missed (at minimum, set an aggressive date for the completion of your research and report of the results)
- Make clear your objections to closing any beds on Ward 4C
- We request that you ask the county to notify you (The Mental Health Commission) and the NAMI Board as well as us (The Diablo Valley Family Coalition) at the moment any discussions are on the table regarding closing any beds on Ward 4C.

Thank you for your prompt attention to this matter.

Sincerely,

The Diablo Valley Family Coalition:

Celi Family	Walnut Creek
Creel Family	Clayton
Foote Family	Walnut Creek
Hough Family	Concord
Kahler Family	Concord
Macaluso Family	Pleasant Hill
Madison Family	Walnut Creek
Maselli Family	San Ramon
Shorteuhous Family	Walnut Creek
Tachiera Family	Danville

Family Coalition contact: Sharon Madison (c_madison@msn.com)

Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding

Please read and answer the following questions based on your experience in working with/receiving services from Contra Costa Mental Health. Your answers will remain anonymous. Your responses will be used to help determine which needs will be funded by Mental Health Services Act (MHSA) Capital Facilities funds in order to construct or renovate a building for new mental health services.

1. **If we had the money to construct or renovate a building for mental health services, which of the following services are most important to you?** ***Please rank them in the order of importance to you. (On a scale of 1 through 16, with 1= most important, and 16=least important)***

RANK IMPORTANCE	SERVICES NEEDED	LOCATION IN COUNTY: Central, East, West, or Centralized (You Pick)	URBAN OR RURAL SETTING? (You Pick)
	ALTERNATIVES TO HOSPITALIZATION:		
	Assessment and Recovery Center (24/7 Urgent Mental Health Care Drop-In Center with Crisis Stabilization Services (serves all age groups other than children)		
	Children's Urgent Care Receiving and Assessment Center		
	Crisis Residential Facility for Young Adults, Adults, Older Adults (unlocked)		
	Peer Operated Crisis Respite Center (i.e., the Living Room, by Recovery Innovations)		
	CULTURALLY APPROPRIATE SERVICES		
	LGBTQQI Education for Families of Youth		
	PEER SUPPORT AND SKILL BUILDING SERVICES		
	Peer Support Specialists and Recovery Coach Services		
	Advocacy Services – Peer Recovery Teams		
	Job Coaching and Enhanced Vocational Services		
	Peer Warm Line		
	Wellness Center for Youth under Age 18		
	INTEGRATED PRIMARY CARE AND MENTAL HEALTH SERVICES		

	Mental Health and Primary Care Services (integrated)		
	Mental Health and Substance Abuse Services (integrated)		
	Wellness Education to Consumers and Family		
	Medication Self-Advocacy and Education Classes		
	Educating Consumers in Selection of Primary Care and Other Physicians and Communication Between Them		
	Your Idea:		

2. **Are there other needs that should be considered? Examples:**
   ____ Transportation
   ____ Other_____

CHECK ALL THAT APPLY:

YOUR EXPERIENCE	[ ] Providing Services [ ] Receiving Services [ ] Family Member [ ] Internship [ ] Advisory Committee [ ] Advocating [ ] Volunteering [ ] Stakeholder	**YOUR RACE/ETHNICITY**	[ ] Caucasian [ ] African American [ ] Asian [ ] Hispanic/Latino [ ] American Indian/Alaska Native [ ] Native Hawaiian/Pacific Islander Other_____

YOUR INTERESTS	[ ] Adult Mental Health Services [ ] Children's Mental Health Services [ ] Older Adult Mental Health Services [ ] Young Adult Services [ ] LGBTQQI Community [ ] Latino Community [ ] Asian/Pacific Island Community [ ] Native American Community [ ] Client Culture Community Other Cultural Communities: _____	**YOUR GENDER:** **YOUR AGE:**	[ ] Male [ ] Female [ ] Transgender [ ] Other Under 18 _____ 18-25 _____ 26-59 _____ 60+ _____

WE ARE PROPOSING CHANGING THE CATEGORIES FOR ALTERNATIVES DUE TO THE FOLLOWING FROM MHSA GUIDELINES:

MHSA Guidelines for Capital Facilities and Technology Needs Component - Capital Facilities Project Proposal - Proposed Guidelines - specifically, ask folks to reference page 3, under Specific Requirements, first bulleted item; ("Capital Facilities funds shall only be used for those portions of land and buildings where MHSA programs, services, and administrative supports are provided; consistent with the goals identified in the Community Services and Supports [CSS] and Prevention and Early Intervention [PEI] components of the county's three year plan."

We are suggesting the following:

FOR CHILDREN/YOUTH:

CSS Strategies:

- For the issue identified as "Failure in Learning Environments", including school failure, out-of-home placements, and involvement in child welfare or juvenile justice systems:
    - "Culturally Appropriate Youth Services"

PEI Strategies

- Families in Need of parenting knowledge and skills
- Immigrant families with communication and parent/child relationship challenges
- Residents of high violence areas of CCC traumatized by that violence
- Families experiencing domestic violence
- Infants and young children of trauma exposed parents
- Children, youth and young adults with early signs of mental illness
- Children, youth, young adults entering or in the justice system
- Children, youth and young adults at risk suicide
- Children and families living with poverty and homelessness

- Adolescents experiencing chronic or extreme stress
- Adolescents aging out of public systems.

FOR TRANSITION AGE YOUTH:

CSS Strategies

- For the issue identified as "Homelessness", "Incarceration", and "Hospitalization or involuntary care", we recommend:
    - "Alternatives to Hospitalization"

PEI Strategies:

- Families in Need of parenting knowledge and skills
- Immigrant families with communication and parent/child relationship challenges
- Residents of high violence areas of CCC traumatized by that violence
- Families experiencing domestic violence
- Infants and young children of trauma exposed parents
- Children, youth and young adults with early signs of mental illness
- Children, youth, young adults entering or in the justice system
- Children, youth and young adults at risk suicide
- Children and families living with poverty and homelessness
- Adolescents experiencing chronic or extreme stress
- Adolescents aging out of public systems.

FOR ADULTS:

For CSS Strategies:

- For the issues of "Homelessness", "Isolation" and the "Inability to Work"
    - We recommend "Peer Run Support Services"

For PEI Strategies:

- Isolated families in underserved cultural populations lacking connections with their communities
- Individuals/families with early signs of mental illness including psychotic illness and co-occurring disorders
- Individuals/families/communities experiencing stigma or discrimination due to mental illness
- Individuals and families living with poverty and homelessness
- Isolated older adults
- Individuals at risk for suicide

FOR OLDER ADULTS:

For CSS Strategies:

- For the issues identified as "Unnecessary Loss of Functioning", leading to: frequent hospitalizations, frequent emergency medical care, involuntary care, and institutionalization.
    - Use "Alternatives to Hospitalization"
    - Use "Integrated Primary and Mental Health Care" (due to frequent emergency medical care).

For PEI Strategies:

- Isolated families in underserved cultural populations lacking connections with their communities
- Individuals/families with early signs of mental illness including psychotic illness and co-occurring disorders
- Individuals/families/communities experiencing stigma or discrimination due to mental illness
- Individuals and families living with poverty and homelessness
- Isolated older adults
- Individuals at risk for suicide

EXPLANATION FOR CHANGES IN THE DRAFT SURVEY:

- Removed: Clinical and Recovery Services (Integrated) – all clinical services provided to mental health clients should be integrated with recovery services – recommendation from MHC/CPAW Capital Facility Workgroup member Kathi McLaughlin.
- Removed: Club House Facility and Wellness and Recovery Center – Contra Costa Mental Health already has a contract with Mental Health Consumer Concerns to operate three Wellness and Recovery Centers (under MHSA Community Services and Support), and contracts with The Clubhouse to provide services (under MHSA Prevention and Early Intervention).
- Removed: Mental Health Outpatient Older Adult – a facility for this purpose is already being renovated to provide these services (funding under MHSA Community Services and Supports, Older Adult Program).
- Removed: Crisis Residential Facility for Children (Alternative to Hospitalization) – removed because of the addition of the Children's Urgent Care Receiving and Assessment Center.
- Added: Children's Urgent Care Receiving and Assessment Center – a component of the Mental Health Recovery Services Campus
- Changed: Renovate Existing Mental Health Outpatient Site to accommodate MHSA Services, i.e., Systems Development (Child) – There are some systems development efforts for children to expand existing wrap-around program. Therefore, it would be necessary to expand/renovate at the current location. There are no funds available to replace an entire Mental Health Outpatient clinic.
- Added: Peer Operated Crisis Respite Center – example of the Living Room, Recovery Innovations
- Removed: "Alternatives to Hospitalization – Example Peer Operated Respite" – made "Alternatives to Hospitalization" an overall general category with specific services listed below it.
- Removed: Vocational Services – in the place of "Vocational Services", we substituted Job Coaching and Enhanced Vocational Services to more clearly define what services might require expansion to an existing program.

- We removed the entire second question, because it really doesn't tie to MHSA services that can be "housed" in capital facilities.

Contra Costa Mental Health – MHSA Survey
Deadline to Return Survey: January 19, 2009

Consumer and Family Member Survey for MHSA Technology Component

Funding is available to improve technology used by Contra Costa County Mental Health Plan to promote wellness and recovery by using technology to

- Establish an electronic medical record to replace paper-based system
- Establish a personal health record, which would allow clients to access part of their medical record, make appointments, communicate with providers, and develop WRAP plans
- Improving access to technology by providing computer resources to consumers in open access areas such as community centers
- Providing a computer-based learning resource to learn of recovery concepts, diagnostic and other medical information, skills development.
- Other uses of technology

Purpose of Survey: To gather feedback directly from consumers, families, and consumer advocates to find the best way to support consumers with new technologies

Please Check One: **[ ] MH Consumer [ ] Family Member**
[ ] Consumer Advocate

Please return the survey to:

Contra Costa Mental Health Services Act
Attn: MHSA Program Manager
1340 Arnold Dr., Suite 200
Martinez, CA 94553
Or
Email: mhsa@hsd.cccounty.us

Topic Areas:

Electronic Medical Record:

One of the chief benefits of the electronic medical record is the ability to capture information once and make this information available to all providers who are involved in a client's care. Currently, clients and clinicians complete a lot of paperwork, and many times this paperwork is redundant. What ways can we use the electronic medical record system to improve the registration process, partnership plans, or any other process that now involves paper?

An EHR allows for easy transfer of client information from one provider to another. Are there any concerns about the privacy of records when we go to an electronic medical record? How can these concerns be alleviated?

Any other thoughts about the electronic medical record?

Personal Health Record:

The PHR is a technology that allows you to access through a computer and internet connection some of your medical record, keep key contact information, and communicate with your provider. What kind of information would you be interested in accessing if a PHR were made available to you? [e.g., next appointment, ability to message to provider, prescriptions, partnership plan]

Is there information that you think should not be included in the personal health record? How much information would you want to be able to see online? [e.g., treatment goals, assessments, diagnosis]

What barriers might prevent a client from using a personal health record? [e.g., lack of access to computers, lack of computer literacy]

Any other thoughts on the PHR?

Computer Resources:

One of the exciting things we can do with MHSA Technology funding is to provide computer resources to clients. This would allow access to the Internet, as well as provide a place for consumers to learn and use applications. What would the ideal setting be for providing computer resources to consumers?

Are there specific things you can think of that consumers really need computers for? [e.g., using the Internet, looking up information on the computer, learning about computers, etc.]

Learning Resource:

We plan to provide a learning resource to consumers and staff as an educational opportunity. For instance, clients could learn about how to develop a WRAP plan, or they could learn more about certain diagnoses. Do you think taking courses on a computer would be beneficial to clients? What topics do you think consumers and family members would be most interested in learning more about?

Can you think of ways consumers could get involved in helping facilitate providing educational opportunities for clients in the system? Are there certain career or vocational interests that would be of more interest to consumers?

Any other input on learning resources?

Other:

Do you have any other input for planning the MHSA Information Technology Component?

Thank you for your input!!

February 4, 2009

A six-page survey (attached) was made available to consumers who attended focus groups, at NAMI meetings, and at MHCC. The objective was to solicit input on issues related to the MHSA IT component proposals. Four broad areas were addressed in the survey – the electronic medical record, the personal health record, a computer resource center, and training opportunities. The ideas generated from each question area are presented below.

Responses to MHSA IT Component Survey Questions:

What ways can we use the electronic medical record system to improve the registration process, partnership plans, or any other process that now involves paper?

Responses:

ELECTRONIC MEDICAL RECORD			
1	What ways can we use the electronic medical record system to improve the registration process, partnership plans, or any other process that now involves paper?		
		# Responses	***% of Total***
	Access to information from other agencies	4	10.0%
	No changes needed	3	7.5%
	Share information using computers	3	7.5%
	Would benefit all parties involved in a client's care	3	7.5%
	Consumer gives info once instead of several times	3	7.5%
	Expediting information effortlessly	2	5.0%
	Could streamline the vast amount of paperwork	2	5.0%
	Need training to ensure accuracy and complete data entry	2	5.0%
	Eliminate duplicate records	2	5.0%
	Minimize errors in record keeping and reporting	2	5.0%

	Minimize errors in patient care	2	5.0%
	Decrease costs in employee time, paper, consumers obtaining copies of records	2	5.0%
	Save time	2	5.0%
	Less stress for consumers	2	5.0%
	Avoid mixups	2	5.0%
	Speed up medical system	2	5.0%
	Most current information in medical record at all times	2	5.0%
	TOTAL	40	100.0%
2	Are there any concerns about the privacy of records when we go to an electronic medical record? How can these concerns be alleviated?	***# Responses***	***% of Total***
	Need passwords and secure website	7	25.9%
	Security	5	18.5%
	Only trained or authorized personnel have access to records	5	18.5%
	No privacy concerns	3	11.1%
	System is fine the way it is	2	7.4%
	Have releases in place-no problems with privacy	2	7.4%
	Consumers indicate which info is confidential or not shared	1	3.7%
	Providers need to pass the HIPAA test	1	3.7%
	Random security checks	1	3.7%
	TOTAL	27	100.0%
3	Any other thoughts about the electronic medical record?	***# Responses***	***% of Total***
	Like that all parties involved can communicate about me	2	14.3%
	Develop a foolproof way to ensure records could not be read by outsiders	2	14.3%
	A good idea	2	14.3%
	Patient Rights Advocates need access to records to hear from both sides	1	7.1%
	Also helpful if pharmacies had access to prescribed medications	1	7.1%
	Helpful for CBO's to have access to medical records	1	7.1%
	Make job easier for caregivers, consumers, nurses and clinicians	1	7.1%
	Computerized medical records are the future	1	7.1%

	Timesaving	1	7.1%
	Keep one's care personalized	1	7.1%
	For dangerous patients, medication compliance shouldn't be private	1	7.1%
	TOTAL	14	100.0%
	PERSONAL HEALTH RECORD (PHR)		
4	What kind of information would you be interested in accessing if a PHR were made available to you? [e.g., next appointment, ability to message to provider, prescriptions, partnership plan]	***# Responses***	***% of Total***
	Appointment times	11	23.4%
	Filling & refilling prescriptions	9	19.1%
	Partnership Plan	5	10.6%
	Send message to one or more providers	4	8.5%
	Diagnoses	3	6.4%
	None	2	4.3%
	Lab results	2	4.3%
	Email provider	2	4.3%
	Record of prescriptions	2	4.3%
	Complete medical record	2	4.3%
	Grievance and managed care forms	1	2.1%
	Appeal forms	1	2.1%
	Change of provider forms	1	2.1%
	Rights & Responsibilities	1	2.1%
	Docs & Nurses notes	1	2.1%
	TOTAL	47	100.0%
5	Is there information that you think should not be included in the personal health record? How much information would you want to be able to see online? [e.g., treatment	***# Responses***	***% of Total***

	goals, assessments, diagnosis]		
	Certain health conditions already protected, e.g., HIV, etc.	1	33.3%
	Social Security Number	1	33.3%
	Leave as is	1	33.3%
	TOTAL	3	100.0%
	Things to See	***# Responses***	***% of Total***
	Diagnoses	8	22.2%
	Treatment goals	6	16.7%
	Assessments	5	13.9%
	Treatment plan	5	13.9%
	Medical records	2	5.6%
	Next Appt.	2	5.6%
	Hospitalizations	2	5.6%
	Complete medical record	2	5.6%
	Leave it as is	1	2.8%
	Current medications	1	2.8%
	Lab results	1	2.8%
	Pt. Response to staff suggestions	1	2.8%
	TOTAL	36	100.0%
6	What barriers might prevent a client from using a personal health record? [e.g., lack of access to computers, lack of computer literacy]	***# Responses***	***% of Total***
	Lack of computer literacy	12	38.7%
	Lack of access	11	35.5%
	Doesn't own a computer	4	12.9%
	Lack of understanding diagnosis	1	3.2%
	Need privacy in public venues	1	3.2%
	Paranoia	1	3.2%
	Mentally ill people aren't likely to use it	1	3.2%
	TOTAL	31	100.0%

7	Any other thoughts on the PHR?	*# Responses*	*% of Total*
	System would be convenient for staff	2	33.3%
	Is a win/win idea for staff and consumers to	1	16.7%
	Privacy concerns	1	16.7%
	Only as good as the info in it	1	16.7%
	Will save time and money for everybody	1	16.7%
	TOTAL	6	100.0%
	COMPUTER RESOURCES		
8	What would the ideal setting be for providing computer resources to consumers?	*# Responses*	*% of Total*
	Community Centers	5	20.0%
	Rubicon	4	16.0%
	Clubhouse	4	16.0%
	Library	3	12.0%
	By phone	2	8.0%
	A place open most days and time w/personnel to help	2	8.0%
	MHCC Wellness & Recovery Centers	1	4.0%
	Crestwood Healing Center	1	4.0%
	Clinic sites	1	4.0%
	Senior Centers	1	4.0%
	School	1	4.0%
	TOTAL	25	100.0%
9	Are there specific things you can think of that consumers really need computers for? [e.g., using the Internet, looking up information on the computer, learning about computers, etc.]	*# Responses*	*% of Total*
	Computer education	6	14.0%
	Education	5	11.6%

	Accessing job information	4	9.3%
	E-mail	4	9.3%
	Diagnoses	4	9.3%
	Research	4	9.3%
	Access to the MHR	3	7.0%
	Consumer support groups	3	7.0%
	Access to the Internet for education	2	4.7%
	Resumes	2	4.7%
	Instead of a newspaper	2	4.7%
	General Information	2	4.7%
	Medical Information	1	2.3%
	Internet	1	2.3%
	TOTAL	43	100.0%
	LEARNING RESOURCES		
10	Do you think taking courses on a computer would be beneficial to clients? What topics do you think consumers and family members would be most interested in learning more about?	***# Responses***	***% of Total***
	More about mental health	5	9.4%
	Education on diagnoses	4	7.5%
	General information	4	7.5%
	Jobs	3	5.7%
	New treatments or drugs	3	5.7%
	Education on Sx's	2	3.8%
	Education on triggers	2	3.8%
	Education	2	3.8%
	Internet courses	2	3.8%
	Support with MH issues	2	3.8%
	Diagnoses	2	3.8%
	Computer courses	2	3.8%
	Treatment Plan	1	1.9%

	Interactive WRAP Plan	1	1.9%
	Housing Availability	1	1.9%
	Interactive work books on MH diagnoses	1	1.9%
	Creating resumes	1	1.9%
	Using email and the Internet	1	1.9%
	Relapse prevention	1	1.9%
	Productive ways to spend idle time	1	1.9%
	Meditation exercises	1	1.9%
	Healthy diet	1	1.9%
	Life skills	1	1.9%
	Vocational training	1	1.9%
	Avocational training	1	1.9%
	Website links	1	1.9%
	Instant messaging	1	1.9%
	Medical terminology	1	1.9%
	Social websites	1	1.9%
	Opportunities for self employment	1	1.9%
	Resources for clients	1	1.9%
	Treatment Plan	1	1.9%
	TOTAL	53	100.0%
11	Can you think of ways consumers could get involved in helping facilitate providing educational opportunities for clients in the system? Are there certain career or vocational interests that would be of more interest to consumers?	***# Responses***	***% of Total***
	Consumers facilitating for consumers	7	41.2%
	Word of mouth	3	17.6%
	Public speaking	2	11.8%
	Post flyers for volunteers in physician offices,	1	5.9%
	Better public transportation	1	5.9%
	Job training such as Spirit program	1	5.9%

	Peer counseling	1	5.9%
	Job searching and resume writing	1	5.9%
	TOTAL	17	100.0%
12	Any other input on learning resources?	***# Responses***	***% of Total***
	Resources for work	2	16.7%
	WRAP Plan	2	16.7%
	Job Training	2	16.7%
	Encourage consumers to learn computer	1	8.3%
	skills at adult education and community colleges	1	8.3%
	Websites should be extremely user friendly	1	8.3%
	Keyboarding software to learn or improve typing skills	1	8.3%
	Ensure accuracy of websites used	1	8.3%
	Excited to see the final result	1	8.3%
	TOTAL	12	100.0%
13	Do you have any other input for planning the MHSA Information Technology Component?	***# Responses***	***% of Total***
	A great idea	2	22.2%
	Enable to be more independent	2	22.2%
	Learn skills to care for myself	2	22.2%
	Patients Rights Advocates need access to online records	1	11.1%
	More public input to legislatures on MH issues & policies	1	11.1%
	Would allow electronic monitoring of compliance w/injectable meds	1	11.1%
	TOTAL	9	100.0%

Section I. Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

II.I.1. Major Community Issues Identified Through Community Planning Process

The major community issues identified by each Stakeholder Planning Group are listed in the table below. Those which have been selected to be the focus of MHSA services over the next three years are identified with an asterisk (*).

Community Issues Identified in the Public Planning Process			
Children/Youth	**TAY**	**Adults**	**Older Adults**
1. Failure in Learning Environments* (Includes: School Failure)	1. Homelessness*	1. Homelessness*	1. Unnecessary Loss of Functioning* (Includes: Frequent hospitalizations, frequent emergency medical care, inability to work, inability to manage independence, involuntary care and institutionalization)
2. Out-of-Home Placements	2. Incarceration	2. Isolation	2. Isolation*
3. Involvement in child welfare or juvenile justice systems	3. Hospitalization or Involuntary Care	3. Inability to Work	

All four stakeholder groups received training and technical assistance on the logic model used in the Community Service and Supports guidelines. This included an overview of the DMH's requirements to identify Full Service Partnerships and System Development Strategies.

I.I.2. Factors or Criteria Leading to Selection of Starred (*) Issues

Selection of Children's Issues

The Children's Stakeholder Planning Group identified many issues before selecting its priority issue (above). This included a review of community input from surveys, focus groups and community meetings (included as Attachment 7 to this plan) as well as existing utilization and demographic data. Issues were prioritized through facilitated discussion. It was generally agreed that many critical issues identified in the brainstorming phase of the discussion (including family problems, involvement with child welfare or juvenile justice systems, and out-of-home placement) would manifest themselves in the more visible issue of ability to function in learning environments. The Children's Stakeholder Planning Group wrote:

> *Reductions in funding to children's mental health services over the last several years have created a critical situation. Existing services are limited and many have long waiting lists. It is in this context that we plan for the MHSA.*

When it becomes obvious to health and other professionals, and possibly to parents/caregivers, that a child or adolescent is having problems functioning safely and productively in his/her home, learning environment and/or community, it can be assumed that the child has serious social, emotional or physical needs that are inadequately met. Healthy functioning and reasonable growth in the home and in the learning environment are the best indicators that a child will develop into a healthy and productive young adult.

When health professionals and educators assist families in meeting the social, emotional and physical needs of their children, the community in general is a happier and healthier place for all of us.

It is important to note that the Stakeholder Group refined DMH's issue of "school failure" to recognize that, especially for younger children, many learning environments are not specifically schools. The concept was broadened to include these additional learning environments.

Selection of Transition Age Youth Issues

As with the Children's Group, the Transition Age Youth Stakeholder Planning Group reviewed existing data and community input and identified pivotal issues which they viewed as not only of primary importance, but as the visible results of secondary issues such as school failure and out-of-home placement. The group wrote:

There are three core issues: homelessness, incarceration and hospitalization/involuntary care. These are difficult to separate as involvement in any one can lead to involvement in another. Then a ripple effect occurs. Youths who are homeless, incarcerated and/or hospitalized stand a very good chance of having difficulty in regular school settings or holding a job. Additionally, the likelihood of being placed in foster care or a group home is increased.

Selection of Adult Issues

As with the other groups, the Adult Stakeholders Planning Group recognized that a few pivotal issues were the most primary and most visible manifestations of mental illness in the population as well as other key community issues such as incarceration, substance abuse and family problems. They wrote:

The goal for adults with serious mental illnesses should be "greater membership in society." But due to a lack of appropriate integrated services at the time people need them, the major impacts on adults with serious psychiatric disabilities are:

- *An inability to financially support themselves or access benefits,*
- *Isolation due to the effects of mental illness and discrimination, and*
- *Homelessness or inappropriate housing.*

Any one of these can initiate a cycle that leads to the others. Common outcomes are incarceration and/or institutionalized care without integrated services and a continuum of supports.

While the Adult Stakeholder Group ultimately selected the "homeless without shelter" population for Full Service Partnerships, there was major discussion within the group, especially among those who advocated for services for those who may not be without shelter - yet. This includes those who are at imminent risk for homelessness: Consumers being discharged from institutions, jails or hospitals, and consumers in unstable housing. It came down to a vote within the group with a slim majority voting for those "without shelter." The portion of the group that wanted a broad definition of homelessness also created a "Minority Report" that was given to the Mental Health Director at the final Stakeholder Planning Group meeting, advocating for the more inclusive population.

Selection of Older Adult Issues

The Older Adult Stakeholder Planning Group reviewed existing data and identified many issues before selecting its priority issues. Additional issues included: In-crisis, complex presentation, in the community without supports and resources (variation on isolated), in institutions without supports and resources, homeless, resistant to treatment and/or recovery, uninsured or underinsured, no employment or meaningful activity. In selecting the starred issues, the Planning Group wrote:

> *For older adults with serious mental illnesses, there is a dynamic between "unnecessary loss of ability to function" (lack of resources available that results in a downward spiral) and "isolation." Either of these two issues can stimulate the other, and they are exacerbated by lack of transportation, lack of case management services, language barriers, and discrimination based on age/race/alternative life styles. From isolation/unnecessary loss of ability to function follows a cascade of secondary problems such as: inability to attend to health care needs; inability to care for one's self; inability to work; substance abuse; and hopelessness. Common outcomes of this pattern are institutionalization and homelessness.*

Unnecessary loss of ability to function is not a specific category mentioned in the MHSA but was identified as critical by the Stakeholder Planning Group. It can be viewed as a "Super" category that includes several MHSA categories including: frequent hospitalizations, frequent emergency medical care, inability to work, inability to manage independence, involuntary care and institutionalization.

I.I.3. Racial, Ethnic and Gender Disparities Within Selected Community Issues

Children

The Children's FSP focuses on youth with SED, without any medical insurance, who have experienced failure in their learning environments. We know that these children are more likely to be lower income. At present, CCMH serves 8.2% of the population of families with children who live in poverty. Of this lowest income served population, African Americans and Whites are most highly served and Asians/Pacific Islanders and Latinos are the most underserved at 3.7% and 4.4% respectively.

We know from experience that children who experience homelessness are more likely to have serious emotional disturbances. This may be, in part, from the experience of homelessness itself. It may also be because risk factors that contribute to homelessness (e.g.: low income, low education, substance abuse, parental psychiatric disabilities) also contribute to SED in children.

We also know that children who enter the foster care system are more likely to have SED. As with homelessness, we know that the risk factors that led them into the foster care system are some of the same risk factors for SED. As with homelessness, we know that the experience of foster care itself can (in some instances) lead to SED.

Finally, we know that older children with SED are more likely to enter the juvenile justice system. And that children who enter the juvenile justice system are more likely to have or develop SED. A snapshot of youth in juvenile hall on a single day in October, 2005 shows that 89% are male. 54% are African American, 25% are Latino, and 18% are White.

Transition-Age Youth

The TAY FSP focuses on youth with SED, who are homeless or at imminent risk of homelessness. We know that these youth are low income. They are more likely to be gay/lesbian or questioning their sexual identity. Many have aged out of the foster care system with few supports and inadequate education and life skills. The population is disproportionately of color. Many have experienced episodes of homelessness before.

We know from experience that youth who experience homelessness are more likely to have serious emotional disturbances. This may be, in part, from the experience of homelessness itself. It may also be because risk factors that contribute to homelessness (e.g.: low income, low education, entrance into child welfare and criminal justice systems, substance abuse, parental psychiatric disabilities, parental substance abuse) also contribute to SED in youth.

2005 Data from Homeless Encampment Outreach efforts conducted by Contra Costa County Homeless Services shows that, of 4,578 contacts with homeless individuals, 34% were under the age of 25. Those in encampments (clustered in open areas within the county) are the most chronically homeless, with 71% having been homeless for more than a year.

We know that children who enter the foster care system are more likely to have or develop SED. As with homelessness, we know that the risk factors that led them into the foster care system are some of the same risk factors for SED. As with homelessness, we know that the experience of foster care itself can (in some instances) lead to SED.

Adults

The Adult FSP focuses on seriously mentally ill adults who are homeless without shelter. These are likely to be chronically homeless adults. Many have aged out of the foster care system with few supports and inadequate education and life skills. The population is disproportionately of color. Some of these individuals are homeless because of their mental illness. Some have come out of jail into homelessness. The mentally ill are also more likely to go to jail.

2005 Data from Homeless Encampment Outreach efforts conducted by Contra Costa County Homeless Services shows that, of 4,578 contacts with homeless individuals, 71% had been homeless for more than a year, with 23% homeless for more than 5 years. 55% of those contacted were White, 31% were African American, and 11% were Latino. When compared to countywide census data (2000) data, we see that African Americans are significantly over represented in the chronically homeless population.

Lower education is a factor in homelessness. Homeless Encampment Data also shows that 26% of the homeless do not have a high school diploma or equivalent – compared to 13% countywide. 80% of these homeless individuals do not have a college degree – compared to 57% countywide.

Of mental health clients served by Project Hope – a homeless outreach program, 85% reported substance abuse, 53% of whom reported abusing alcohol.

Older Adults

Older adults have complex factors contributing to and/or complicating mental illness. Older adults become increasingly isolated in their homes. This can exacerbate mental illness, and make it harder to find support or treatment. Declining health can also exacerbate and/or mask mental illness. Declining health can lead to multiple hospitalizations and or institutionalization. Repeated hospitalizations or institutionalization can lead to loss of one's home. Additionally, the increased number of medications taken by older adults can create behavioral disturbances that are difficult to diagnose or treat.

Older adults are at increased risk of dementia – recognized as a physical/medical problem rather than a mental illness. Because of this physical definition, it is treated in medical settings and reimbursed as a medical event. But dementia is difficult to differentiate from mental illness and mental health care is often not provided – even when co-occurring. To overcome this, physical and mental health diagnosis and treatment need to be jointly provided.

Co-Occurring Developmental and Psychiatric Disabilities

In our focus group process, we learned more about the gap in services and limited partnerships with agencies and organizations that provide services to the population with the co-occurring issues of developmental and psychiatric disabilities. Experts who participated in this focus group were quite clear regarding recent studies showing the increased prevalence of mental disorders among the developmentally disabled who also experience significant stigma, discrimination, and higher

frequency of trauma. The need to further explore the data and collaborate further with DD-focused organizations to develop culturally relevant services was raised.

LGBT Population
Lesbians, gays, bisexuals and transgender persons cross almost all age groups. Their characteristics and their needs are complex. Within this population, there are many dynamics to consider when offering programming – such as the differing mental health needs of ethnically specific LGBT communities and the complexity of the issue of the "Down Low" dynamic where stigma affects the health of the general community. The needs of the HIV/AIDS-infected LGBT consumer must also be considered. In order to better serve youth, focus groups suggested a greater presence in the schools.

FROM PREVENTION AND EARLY INTERVENTION PLANNING:

TOP Stakeholder Priority Strategies to Address Target Populations
0-25 Age Group

KEY: U=Universal prevention, S=Selective prevention, EI=Early intervention

Strategy	*# of Votes*
1. Families in need of parenting knowledge and skills	
▫ community-based classes or playgroups – U or S	20
▫ screening and referral/gate-keeper training – S	16
▫ clinical interventions – EI	15
▫ peer support – S or EI	9
2. Immigrant families with communication and parent/child relationship challenges	
▫ pro-social peer activities/youth development – U or S	17.5
▫ screening & referral/gatekeeper training -S	15
▫ peer support for families/parents– S	14
▫ system navigation -S	12
▫ traditional interventions – S or EI	11
3. Residents of high violence areas of Contra Costa County traumatized by that violence	
▫ system readiness/trauma-informed systems of care – U	20
▫ peer support for families/individuals within families – S	15
▫ clinical interventions – EI	14
▫ community efforts – U or S	8
4. Families experiencing domestic violence	
▫ clinical interventions – EI	13

- community-wide educational messages -U 10
- screening and referral/gatekeeper training – S 9
- system readiness/trauma-informed systems of care – U 9

5. Infants and young children of trauma exposed parents

- clinical interventions – EI 15
- peer support for parents– S 14
- screening and referral/gate-keeper training – S 12

6. Children, youth and young adults with early signs of mental illness

- screening and referral/gatekeeper training – S 16
- clinical interventions -EI 12
- system readiness/trauma-informed systems of care -U 11
- family psycho-education-S or EI 9

7. Children, youth, young adults entering or in the justice system

- pro-social peer activities/youth development – U or S 22
- parent and youth peer support/mentoring – S or EI 17
- screening and referral/gate-keeper training – S 10
- system readiness/trauma-informed systems of care – U 9

8. Children, youth and young adults at risk for suicide

- system readiness/trauma-informed systems of care – U 19
- family psycho-education-S or EI 15
- screening and referral/gate-keeper training – U or S 14
- clinical interventions – S or EI 10

9. Children and families living with poverty and homelessness

- system readiness/trauma-informed systems of care – U 17
- screening and referral/gate-keeper training – S 15
- clinical interventions – EI 8

10. Adolescents experiencing chronic or extreme stress

- pro-social peer activities/youth development – U or S 18
- system readiness/trauma-informed systems of care – U 13
- positive adult support/mentoring – U or S 12
- screening and referral/gate-keeper training -S 9

11. Adolescents aging out of public systems

- system navigation -S 17
- system readiness/trauma-informed system of care – U 12
- case management – S 8
- screening and referral/gate-keeper training -S 8

TOP Stakeholder Priority Strategies to Address Target Populations
26+ Age Group

KEY: U=Universal prevention, S=Selective prevention, EI=Early intervention

Strategy	***# of Votes***
1. Isolated families in underserved cultural populations lacking connections with their communities	
▫ system navigation/helplines – S	14
▫ culturally/linguistically appropriate community-wide educ. Messages-U or S	11
▫ community building/engagement – U or S	10
▫ peer support/warmlines – S or EI	10
▫ screening & referral/gatekeeper training – S	8
2. Individuals/families with early signs of mental illness including psychotic illness and co-occurring disorders	
▫ screening and referral/gatekeeper training – S	10
▫ multifamily support groups – S or EI	10
▫ family psycho-education- S or EI	8
▫ clinical interventions – EI	7
▫ service provider & law enforcement education – U	6
3. Individuals/families/communities experiencing stigma or discrimination due to mental illness	
▫ community building/engagement – U or S	11
▫ service provider (*Added 4/30*: and law enforcement) education – U	9
▫ system navigation/helplines – S	7
▫ media education – U	6
▫ home visitation – S	6
4. Individuals and families living with poverty and homelessness	
▫ community building/engagement – U or S	12
▫ screening and referral/gate-keeper training – S	10
▫ system navigation/helplines – S	6
▫ case management – S	6
▫ clinical interventions – EI	6
▫ peer support/warmlines – S or EI	5
5. Isolated older adults	
▫ peer support/warmlines – S or EI	14
▫ screening and referral/gate-keeper training – S	10
▫ system navigation/helplines – S	10
▫ community building/engagement – U or S	8
▫ clinical interventions – EI	7

6. Individuals at risk for suicide

- screening and referral/gate-keeper training – U or S 12
- community-wide educational messages – U or S 10
- clinical interventions – S or EI 8
- hotlines – S 6
- peer support/warmlines – S or EI 6

ENCLOSURE 2

Mental Health Services Act (MHSA)

Capital Facilities and Technological Needs Component

Capital Facilities Project Proposal

PROPOSED GUIDELINES

FOR THE COUNTY'S THREE-YEAR PROGRAM AND EXPENDITURE PLAN

March 18, 2008

Table of Contents

OVERVIEW

Upon approval by the California Department of Mental Health (DMH) of the Capital Facilities segment of the Capital Facilities and Technological Needs Component, the County may request MHSA funds for specific Capital Facilities projects via the Capital Facilities Project Proposal(s). Guidelines for such Project Proposals are as follows:

PART I: General Capital Facilities Requirements

Capital Facility Definition

A "Capital Facility" is a building secured to a foundation which is permanently affixed to the ground and used for the delivery of MHSA services to individuals with mental illness and their families or for administrative offices. Capital Facility funds may be used by the County to acquire, develop or renovate such buildings or to purchase land in anticipation of acquiring/constructing a building. Capital Facility expenditures must result in a capital asset which increases the County Department of Mental Health's infrastructure on a permanent basis (i.e., acquisition of buildings rather than rental or leased buildings) and must result in an expansion of the capacity/access of existing services or the provision of new services.

Allowable Expenditures

The County may utilize Capital Facilities funds to:

- Acquire and build upon land that will be County-owned
- Acquire buildings that will be County-owned
- Construct buildings that will be County-owned
- Renovate buildings that are County-owned
- Establish a capitalized repair/replacement reserve for buildings acquired or constructed with Capital Facilities funds and/or personnel cost directly associated with a Capital Facilities Project, i.e., a project manager.

The County may utilize Capital Facilities funds to renovate buildings that are privately owned if the building is dedicated and used to provide MHSA services. The County shall:

1) When the renovation is for treatment facilities, describe how the renovation will benefit the clients served in the facility i.e., will result in an expansion of the capacity/access to existing services or the provision of new services;

2) When the renovation is for administrative offices, describe how the administrative offices augment/support the County's ability to provide programs/services, as set forth in the County's Three-Year Program and Expenditure Plan (Three-Year Plan), and

3) Describe how the costs of renovation are reasonable and consistent with what a prudent buyer would incur. The prudent buyer refuses to pay more than the going price for an item/service and seeks to economize by minimizing costs.

4) Demonstrate a method for protecting its capital interest in the renovation. Examples of methods counties might use to protect their capital interest in renovated facilities include, but are not limited to:

    - Instituting a deed restriction on property use in exchange for the resources invested.

- Amending loan agreements to reflect all improvements are considered property of the County which allows the County the option of removing the improvements if specified conditions are not met.
- Acquiring an interest in the property as evidenced by a grant deed.

Specific Requirements

Funds shall be used for land and buildings, including administrative offices, which enable the County and/or contract provider to provide programs/services, as set forth in the County's Three-Year Program and Expenditure Plan.

- Capital Facilities funds shall only be used for those portions of land and buildings where MHSA programs, services and administrative supports are provided; consistent with the goals identified in the Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) components of the County's Three-Year Plan.
- Land acquired and built upon or construction/renovation of buildings using Capital Facilities funds shall be used to provide MHSA programs/services and/or supports for a minimum of twenty years.
- All buildings under this component shall comply with federal, state and local laws and regulations including zoning and building codes and requirements; licensing requirements, where applicable; fire safety requirements; environmental reporting and requirements; hazardous materials requirements; the Americans with Disabilities Act (ADA), California Government Code Section 11135 and other applicable requirements.
- Capital Facilities funds may be used to establish a capitalized repair/replacement reserve for buildings acquired or constructed with Capital Facilities funds. The reserve will be controlled, managed, and disbursed by the County.
- The County shall ensure that the property is updated to comply with applicable requirements, and maintained as necessary, and that appropriate fire, disaster, and liability insurance coverage is maintained.
- Under limited circumstances Counties may "lease (rent) to own" a building. The County must provide justification why "lease (rent) to own" is preferable to the outright purchase of the building and why the purchase of such property, with MHSA Capital Facilities funds, is not feasible.
- For purchase of land with no MHSA funds budgeted for construction of a building or purchase of a building (i.e. modular, etc.), the County must explain its choice and provide a timeline with expected sources of income for the planned construction or purchase of building upon this land and how this serves to increase the County's infrastructure.

Examples of Costs

Examples of costs for which Capital Facilities funds may be used:

- To purchase a building for use as a clinic, clubhouse, wellness and recovery center, an office space, etc., where the County is the owner of record.
- To purchase a building where vocational, educational and recreational services are provided to individuals and families to support MHSA services and the County is the owner of record.
- To purchase land where a clinic, clubhouse or other types of buildings will be built that support MHSA services and the County is the owner of record.

- To make an existing building more accessible to clients and family and compliant with the ADA and California Government Code Section 11135.
- To establish a capitalized repair/replacement reserve for a building acquired with Capital Facilities funds.
- To purchase a modular building for mental health services located on school grounds.
- To cover costs associated with construction of a new building on land including parking lots, sidewalks, easements, exterior lighting, initial landscaping, etc.
- To renovate existing space to create a common room for clients to meet and/or for a computer room for client access.

Examples of costs for which Capital Facilities funds may not be used:

- Master leasing or renting of building space.
- Purchase of vacant land with no plan for building construction.
- Acquisition of land and/or buildings and/or construction of buildings, and establishment of a capitalized repair/replacement reserve when the owner of record is a non-government entity.
- Facilities where the purpose of the building is to provide housing.
- Acquisition of facilities not secured to a foundation that is permanently affixed to the ground (i.e., cars, buses, trailers, or recreational vehicles).
- Operating costs for the building (e.g., insurance, security guard, taxes, utilities, landscape maintenance, etc).
- Furniture or fixtures not attached to the building (e.g., desks, chairs, tables, sofas, lamps, etc).

Restrictive Settings

A restrictive setting is defined as a facility which utilizes a secured perimeter and/or locked exit doors and/or where other mechanical/electrical means are used to prevent the clients from exiting at will.

In general, Capital Facilities funds shall be used for buildings that serve clients in less restrictive settings. However, if a County submits a proposal for a Capital Facilities project, whether acquisition, construction, or renovation, that is a restrictive setting, in accordance with Welfare and Institutions Code (WIC) Section 5847(a) (5), the County must demonstrate the need for a building with a restrictive setting by submitting specific facts and justifications for the Department's review and approval as follows:

- There is an unmet need within the County for a restrictive facility in order to adequately serve clients with serious mental illness and/or emotional disorder.
- These needs cannot be adequately served in a less-restrictive setting. The County shall include specific reasons to substantiate the inability to meet the needs in a less-restrictive setting.
- It is not feasible to build the required facility using non-MHSA funds. The County shall include specific reasons for non-feasibility.
- The County has pursued, and been unable to obtain, other sources of funding.
- The proposal for a restrictive facility was developed through a Community Program Planning Process and Local Review Process in accordance with Title 9 California Code of Regulations (CCR) Sections 3300, 3310, and 3315.

CONTRA COSTA MENTAL HEALTH – MHSA – INFORMATION TECHNOLOGY FOCUS GROUP

Wednesday, January 21, 2009

11:00 am to Noon

ATTENDEES:

- Jennifer Tuipulotu, Community Support Worker, MHSA Older Adult Program
- Dianna Collier, Community Support Worker, Parent Partner
- Sean Kleen, NAMI

The MHSA Technology Consumer Staff Focus Group convened on January 21, 2009, at 11:00 a.m. There were a total of 3 MH consumer staff present for the meeting. An introduction to the MHSA Technology component was provided (see attached). The purpose of the focus group was described:

> "To gather feedback directly from consumer staff to find the best way to support consumers with new technologies".

Questions were posed to the Focus Group on the following subjects:

1. Electronic Medical Records (positive/negative, benefits, security, privacy, paper/electronic, transfer of information, etc.)
    a. <u>Responses:</u>
        i. Need to make sure the EHR is secure and allows only access to providers who need the information for treatment purposes
        ii. Consumers should be able to state through the consent process what information will be shared with other providers
        iii. Would be great to integrate the mental health record with physical health records. This is necessary as info from both systems ensures proper
        iv. Need an opt-out consent process, so clients can limit sharing of PHI to other providers
        v. An EHR would be a great asset to system and clients would have more confidence that they are receiving quality care. When you need to duplicate your information and share your story over and over depending on where you are receiving services, you lose confidence that the system is working for you and providers are communicating with each other.

2. Personal Health Record (technology allowing consumers to access some of their medical record, keep key contact information, communicate with provider, etc.)

    a. Responses:

        i. Some consumers might have issues with using computers and accessing their medical information due to their mental illness

        ii. Make sure the data is not stored in cache memory on the computer

        iii. Make sure it is an opt-in process. Not everyone would want to use a PHR and people should be given the choice

        iv. Be able to ask doctor/therapist questions through secure form on PHR site

        v. Make sure system automatically locks out after some period of non-use, like 15 minutes

        vi. It would be great for parents who have children in the system, to be able to see their diagnosis and other medical information. They don't necessarily get this from the provider. The existing diagnoses are not necessarily valid or updated and vary a lot from provider to provider.

        vii. Would be a great asset to be able to see and make appointments on-line. This is currently a very frustrating experience, especially for consumers who need to use public transportation to get to their appointments.

        viii. A PHR could be helpful for setting up wraparound meetings because they involve so many people and it's hard to coordinate meetings.

        ix. One of the best things about having a PHR is the ability to have better communication with providers.

        x. Need to make the PHR accessible with various language versions, especially Spanish.

        xi. Need to have trainings on how to access PHR and how to use it, especially for computer illiterate people. Lots of consumers don't know how to use computers, especially older adults.

3. Computer Resources (provision of computer resources to clients, access to Internet, learn/use applications, etc.) and Learning Resources

    a. Responses:

i. One great use of a computer resource would be the ability to provide trainings to consumers – on how to use computers, how to use applications on the computer

ii. Access to computers would help consumers find local resources that they can use, for example, for housing resources, job resources, accessing the 211 database

iii. Computers can be empowering. Consumers can learn more about diagnoses and other health information, finding support groups

iv. Computers are a way to teach self-sufficiency

v. Access to computers would be a great way to help consumers communicate with others through email.

vi. Another idea would be to set up an online forum to ask questions to other people with similar interests, kind of like a blog.

vii. Consumers could further their education more easily through online training

viii. Computer resources should be regionalized so consumers can get to them easily.

4. General Comments/Input:

    a. <u>Responses:</u>

        i. Need to make survey more available for consumers to provide input.

<u>NEXT STEPS:</u>

Sean agreed to distribute the survey to other settings (e.g., NAMI, MHCC) so more consumers could provide input. He was given 25 surveys to distribute and will make more copies of the survey if necessary.

CONTRA COSTA MENTAL HEALTH – MHSA – INFORMATION TECHNOLOGY FOCUS GROUP

Thursday, December 18, 2008

11:00 am to Noon

ATTENDEES:

- Diana Classen, MH Consumer
- Cheryl A. Virata, MH Consumer
- Nadine Drummer, MH Consumer
- Gabe Hill, MH Consumer
- Sherry Bradley, MHSA Program Manager
- Loretta Williams, Mental Health Consumer Concerns
- Michael Aiman, MH Consumer, Behavioral Health Court
- Jack Feldman, MH Consumer
- Gloria Cello, MH Consumer
- Wanda Thomsa, MH Consumer
- Danny Wilcox, MH Consumer
- Steve Hahn-Smith, Ph.D., CCMH Research & Evaluation Manager

The MHSA Technology Consumer Member Focus Group convened on December 18, 2008, at 11:00 a.m. There were a total of 10 mental health consumers present for the meeting. An introduction to the MHSA Technology component was provided (see attached). The purpose of the focus group was described:

> "To gather feedback directly from consumers, families, and consumer advocates to find the best way to support consumers with new technologies".

Questions were posed to the Focus Group on the following subjects:

1. Electronic Medical Records (positive/negative, benefits, security, privacy, paper/electronic, transfer of information, etc.)

    a. Responses:

        i. Safeguarding security was very important; it was suggested that additional security questions be used where needed;

        ii. Electronic medical record is a positive, would allow a more current/accurate and recent diagnosis;

        iii. More accurate information on medications, side effects, etc., would be available to providers, making treatment more relevant to current situation

2. Personal Health Record (technology allowing consumers to access some of their medical record, keep key contact information, communicate with provider, etc.)

    a. Responses:

        i. What about diagnosis issues? Can we affect changes by communicating with the provider? Can that be affected through PHR?

        ii. The ability to contact one's doctor/therapist over the internet when in crisis, etc., and the ability to get feedback from the provider is very important;

        iii. The question of safeguarding and securing one's PHR information, i.e., if there is a password to access it, what if the password is accidently shared? Suggest some additional security questions be asked to assure that the person inquiring into the PHR is actually the client.

        iv. It would be good to get information about medications on line, i.e., their side effects, and also to find out what medications are covered under Medi-Cal/Medicare Part D.

        v. It would be good to have access to prescription and diagnostic information through the PHR.

3. Computer Resources (provision of computer resources to clients, access to Internet, learn/use applications, etc.) and Learning Resources

    a. Responses:

        i. There are differing levels of use of computers amongst mental health consumers, so it would be good to provide some basic training to consumers in use of computers;

ii. On-line training or tutorial would be good;

iii. There could be different levels of training for mental health consumers, and it would be a good way for some consumers (who have more knowledge/expertise) to training/teach consumers (job skills) to use computers.

iv. The Behavioral Health Court really needs computers;

v. With training, consumers would like to get their appointments on-line (like for medical appointments), and with training, could get mental health appointments on-line, without waiting.

vi. Using computers is becoming a life-skill, and it's important to be trained to use computers, and to be able to teach other consumers to use computers.

vii. Doing a WRAP plan on-line

4. General Comments/Input:

   a. Responses:

      i. Computers provide a way for mental health consumers to learn a new job skill, take courses on-line, make appointments on-line, get prescription information and pharmacy information, etc.

NEXT STEPS:

It was agreed that a Consumer and Family Member Survey for MHSA Technology Component will be sent to Brenda Crawford for distributing to today's participants so they can provide more information. The survey can also be sent out/distributed to consumers in the clinics, the community centers, and through other means.

Attendees at today's focus group also volunteered to attend another focus group, if needed, and also to volunteer to participate in planning and implementation of any information technology related efforts under MHSA Technology Component. Attendees also received a gift card as a thank you for participating and giving feedback.