

Brown Act Highlights

“...Public commissions, boards, and councils and other public agencies in this State exist to aid in the conduct of the people’s business. It is the intent of the law that their actions be taken openly and that their deliberations be conducted openly.”

The following are highlights of the Brown Act, but do not constitute all of the definitions and provisions:

- Requires the people’s business to be conducted in open, noticed meetings and extends to the public the right to participate in meetings.
- An agenda with time and place must be posted at least 96 hours before the meeting in a location freely accessible to members of the public. *Better Government Practices increases the Brown Act requirement from 72 to 96 hours.
- The Brown Act generally prohibits any action or discussion of items not on the posted agenda.
- The agenda should provide instructions for public comment on agenda items, and time to comment on anything within the jurisdiction of the body, but the body generally cannot act or discuss an item not on the agenda.
- The public has the right to attend and observe meetings, and is not required to provide any personal information.
- The body may remove persons from a meeting who willfully interrupt proceedings. If order still cannot be restored, the meeting room may be cleared.
- The public has the right to review agendas and other writings distributed by any person to the majority of the body in connection with a matter subject to discussion or consideration at a meeting.
- A writing distributed to a majority of the body less than 72 hours before the meeting must be made available for inspection at the time of distribution at a public office or location. A writing distributed during a meeting must be made public.
- The body may adopt reasonable time limits on public comments.
- The Brown Act does not require minutes. The body may record a meeting, and the recording must be available to the public upon request. Recordings may be erased after 30 days. There is no prohibition from the public recording a meeting.

WILLIAM B. WALKER, M.D.
Health Services Director
Cynthia Belon, L.C.S.W.
Behavioral Health Services Director



**CONTRA COSTA
MENTAL HEALTH**

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March 20, 2015

Dear CPAW Members,

We are seeking your assistance in implementing an assisted outpatient treatment program here in Contra Costa County. We are convening a workgroup of stakeholders to provide input on program design, and would like your help in identifying up to two individuals from your membership who would be willing to participate and represent the perspective of consumers and family members.

On February 3d our Board of Supervisors passed a resolution to implement an Assisted Outpatient Treatment program (also known as Laura's Law), and directed the County to return with a plan and budget for their consideration. We received community input on February 25th, and are proceeding with the development of a program design. We are now putting a workgroup together that includes representation from consumers, family members, treatment providers (both County and contract providers), the court system and law enforcement.

We anticipate that this workgroup will meet for three sessions in late April and May to review statutory requirements, consider work accomplished to date and input received, and assist in developing a detailed program design. We have reserved the following dates, times and place:

	<u>Session #1</u>	<u>Session #2</u>	<u>Session #3</u>
Date:	Thursday, April 23	Thursday, April 30	Tuesday, May 19
Time:	1:00 – 3:00 P.M.	1:00 – 4:00 P.M.	1:00 – 4:00 P.M.
Place:	50 Douglas Road 2d Floor Sequoia Room Martinez, CA 94553	50 Douglas Road 2d Floor Sequoia Room Martinez, CA 94553	50 Douglas Road 2d Floor Sequoia Room Martinez, CA 94553

Your consideration of potential nominations to the workgroup should clarify which of the above stakeholder groups are being represented, and that no potential personal or financial conflict of interest exists in either the design or implementation of the program. For example, community based organizations who may consider applying to be a service provider should refrain from sending a representative to participate. Individuals nominated and accepted to the workgroup should commit to attending and actively participating in all scheduled sessions.

In the spirit of openly conducting the people's business the public will be invited to observe and comment on the deliberations of this group.

Nominations will be accepted until close of business Wednesday, April 1, 2015. Nominations and/or questions regarding the process should be addressed to Warren Hayes, 925-957-5154, warren.hayes@hsd.cccounty.us, or David Seidner, 925-925-288-3908, david.seidner@hsd.cccounty.us.



Thank you in advance for your consideration and assistance in bringing this service to our County.

Cynthia Belon, L.C.S.W.
Behavioral Health Services Director

cc: William Walker, M.D., Health Services Director

Community Program Planning Process for Fiscal Year 2015-16

The Community Program Planning Process for Fiscal Year 2015-16 built upon the previous year's comprehensive needs assessment and community engagement process by engaging stakeholders in an active public dialogue of both needs identified from the previous year, and introducing emerging public mental health needs. Also input was solicited in anticipation of implementing an Assisted Outpatient Treatment program in Fiscal Year 2015-16.

A community forum was held on February 25, 2014 in which 143 consumers and family members, the Consolidated Planning and Advisory Workgroup, the Mental Health Commission, National Alliance on Mental Illness – Contra Costa, provider organizations and CCBHS staff planned, facilitated and participated in the event. Breakout sessions discussed and prioritized identified and emerging mental health service needs, strategies to address these needs, and provided input on implementing an Assisted Outpatient Treatment program.

In addition to the Community Forum stakeholders provided written input online, and the results of this alternate method of feedback are included below.

Finally, included below is input from five Community Living Room Partnership Conversations held throughout the County that addressed health and behavioral health service needs and suggested strategies. These conversations were designed to include consumer, family members and service provider invitees to discuss needs and solutions that encompassed primary care, mental health, housing and homeless services, and alcohol and other drug services.

1. Identified Needs and Strategies to Meet These Needs

Participants who attended the Community Forum were afforded the opportunity to discuss identified needs from last year's community program planning process, and then each participant assigned five dot markers to the listed needs. The following identified needs from last year's community program planning process are listed in order of dot markers assigned, with summaries of suggested strategies that participants provided to meet these needs:

- Housing and homeless services (42 dots assigned).
 - Housing first – housing should be the first priority for mental health treatment response. Addressing this priority with providing adequate, affordable and appropriate housing can positively impact so many other needs.

- Lack of affordable housing needs a much better coordinated response in matching availability with need. Utilize electronic technology to maintain an up to date data base and assign people to beds by having real time visibility of need versus availability; much like the hospitality industry does today.
- Living homeless, dealing with substance addiction and battling mental illness are examples of conditions that make one feel less a person. Respectful human contact can be all that is needed.
- Homelessness affects children's mental health and performance in school. Educators need more training and partnership with mental health providers.
- Need more flexibility in housing resources, such as funds for application costs, transportation, maintenance costs in order to get and keep housing.
- Need more transitional housing; we have supported housing and shelter beds.
- Mental health consumers with a criminal record cannot get housing.
- Convert vacant existing public buildings, such as at the Concord Naval Weapons Station, for temporary housing.
- Assistance with meaningful activity (29 dots assigned).
 - People need training on activities of daily living and life coaching as part of their treatment plan so that they can gain self-sufficiency and better manage their resources.
 - Need to link preparation for employment activities with mental health treatment.
 - Assist people get involved in volunteer activities as a bridge to employment.
 - There needs to be a clubhouse model service in West and East County.
 - Integrate recreational therapy activities as part of the mental health treatment plan.
- Integration between service providers (25 dots assigned).
 - Necessary services do exist, but they are either unknown, hard to access, inconvenient to access, not integrated, or otherwise confusing.
 - Integration of health services and behavioral health services is vital, as lack thereof leads to system confusion, ineffective treatment, and is dangerous to a person's recovery.
 - People have to start all over again when they go to a new provider. Have the current provider go with the client to ensure a warm hand-off to a new provider.

- Allow staff from contract agencies to communicate electronically with county operated service providers and each other to share information and coordinate services.
- Crisis response (24 dots assigned).
 - Need a much larger and more immediate mobile response to persons in crisis.
 - The 5150 and psychiatric emergency service (PES) response continually needs to be re-evaluated to ensure the most kind and humane response possible,
 - School counselors need to be better trained to deal with students in emotional crisis.
 - Ambulances are expensive and traumatizing. Provide less expensive transportation in a crisis situation, if appropriate.
- Intervening early in psychosis (22 dots assigned).
 - Kids can be helped at an early age. Reluctance to assign a diagnostic label prevents help at the right time, as Medi-Cal only funds if medical necessity is documented with a diagnosis of seriously emotionally disturbed.
 - Train teachers how to identify a child with mental health problems.
 - We need to engage at risk young adults in healthy activities before they become seriously mentally ill.
- Children inpatient beds (21 dots assigned).
 - There are no children's in-patient psychiatric beds in the County. Kids are sent far away. This separates them from their families and prevents access.
 - Consider strengthening lower levels of care, such as group homes, to lessen the incidence of children needing to be put in locked facilities.
 - Put an emphasis on services to children and foster care providers where children are seen as at risk, but not yet placed in a locked facility.
- Support for peer and family partners (19 dots assigned).
 - Create more positions for peer and family member providers, develop career progression capacity, and assist them in promotional opportunities.
 - Pay them a living wage.
- Navigating the system (18 dots assigned).
 - Need more information on available resources. Most people don't realize resources are there until they have been through a mental health issue.
 - Knowing what resources and how to navigate them is a very difficult task, even by service providers employed by the system.
 - There is no navigation between the mental health and education system.

- Work on improving system navigation on multiple levels, including system mapping and guidance, resource collection and distribution, and ensuring that there is no wrong door to services, to include the person's front door.
- Create an easy to understand and use flow chart to help people get to the right place.
- Cultural/linguistic appropriate outreach and engagement (18 dots assigned).
 - There are still cultural/ethnic groups who do not receive sufficient mental health services, such as transgender women.
 - Need to develop culturally appropriate means for identifying and reaching out to those communities who do not participate in treatment or current forums to identify their mental health needs.
 - Make mental health care more accessible and less stigmatizing to individuals who identify as lesbian, gay, bi-sexual, transgender, or who question their sexual identity.
- Access to services (17 dots assigned).
 - Busses take hours. Take people to and from their mental health appointments.
 - Have health care needs coordinated with mental health needs so that there are not multiple trips.
 - Peer providers should be available to coach consumers how to take public transportation, to include riding along with them.
 - Need an easier access to all services. It takes too long.
 - Allow consumers to access the electronic mental health record system to make appointments and receive follow up reminders.
 - Develop a system wide transportation response that can coordinate and more efficiently apply resources.
- Supporting family members and significant others (14 dots assigned)
 - Provide more and better education and communication regarding mental health treatment and medications provided.
 - Provide peer mentoring and counseling to family members and significant others.
 - Need more family support advocacy in East and West County.
 - Provide suicide prevention training for family members, such as identifying early warning signs, how to get help, and follow up.
- Serve those who need it the most (12 dots assigned)
 - Need a better response to those who are dangerous to themselves and their family and friends, and won't take treatment. Hopefully implementing Laura's Law here will address this.
 - Police responders should be trained to safely respond to people who are severely compromised with mental health issues.

- Integration between levels of care (11 dots assigned)
 - Need an agreed upon means to support people from pre-break through hospitalization.
- Care for homebound frail and elderly (9 dots assigned)
 - Mobile teams consisting of mental health treatment providers, health care workers and peer providers should provide care to the homebound elderly in their homes.

2. Emerging Needs and Strategies to Meet These Needs

Participants discussed service needs that were not listed from last year, and provided suggested strategies to meet these needs.

- Trauma informed care
 - Returning veterans are falling through the cracks. Need to partner with veteran's programs to ensure our returning service men and women get the care they need.
 - Provide grief support for families undergoing loss.
 - Assist coping with the trauma of neighborhood and gang violence and immigration issues.
- Education through social media
 - Utilize today's social media technology to provide community education on reducing stigma and discrimination.
 - Keep 211 information current and spread awareness of this resource.
- Improved program response
 - As programs demonstrate they are not addressing the needs for which they are funded then take away the funding and give it to other programs.
- Increased funding
 - The need for public mental health care keeps increasing, but public funding does not keep up. Stakeholders should coordinate efforts to influence the political process to bring in more dollars to meet this increasing need.
 - There is inadequate reimbursement for providing services, with too much time taken to complete claim forms for billing.
 - Need more funding to attract the most qualified professionals.
- Persons with developmental and mental health issues
 - Service providers of persons with the co-occurring issues of mental health and developmental disabilities, such as autism and Down's syndrome, often do not provide a coordinated response that efficiently and effectively applies appropriate resources. Systems that serve these individuals need

to facilitate dialogue, cooperation and remove system barriers to coordinated service delivery.

- Youth with co-occurring mental health and substance abuse issues
 - Transition age youth often experience the compounding adverse effects of alcohol and other drugs with mental health issues. Mental health providers and substance abuse counselors should develop a developmentally appropriate coordinated response to this at risk population.
- Support our behavioral health workers
 - Develop and support all behavioral health workers, with emphasis on those working in the most chronically stressful environments. Provide pay commensurate with skills needed, a healthy work environment, and the leadership and support needed for our workforce to provide the best care possible.

3. Implementing an Assisted Outpatient Treatment (AOT) Program

Participants in the community forum provided input on how they would like an assisted outpatient treatment program designed. They responded to the following questions:

- How would you suggest we engage persons who are eligible for AOT?
 - Have a mobile team capable of responding to crisis situations, and capable of determining whether an individual is a threat to him/herself or others.
 - Outreach to potentially eligible individuals needs to be caring and client centered.
 - Outreach staff need to be experienced in recognizing and treating symptoms of trauma, and experienced with persons under the influence of multiple psychoactive substances.
 - Staff need to be competent in responding to unique cultural and ethnic differences. Capacity in non-dominant languages needs to be available.
 - Prioritize engaging those individuals who pose a danger to others.
 - Prioritize those individuals from Contra Costa who are being released from out of county locked psychiatric facilities.
 - Partner with law enforcement and emergency medical treatment (EMT) staff, and ensure they are trained in mental health crisis intervention (CIT).
 - Develop and implement a training curriculum for all staff at potential places of referral regarding AOT and protocol for referral.
 - Train all affected parties on 5150 statute, and follow up to ensure provisions are uniformly applied.

- Develop positive working relationships with places where potentially eligible individuals would be identified, such as psychiatric emergency services (PES) and inpatient psychiatric hospitalization (4-C).
- Client rights and the benefits of AOT need to be clearly and consistently communicated.
- AOT staff should develop a partnership with Adult Protective Services.
- Multi-media communication of the program should educate the community and positively communicate rights and benefits that reflect actual practice.
- Outreach should also engage the individual's family and support network to assist the individual participate in treatment.
- Peer and family provider staff should be available to assist the individual throughout the process, to include system navigation and transportation assistance.
- Establish a staffed AOT hot line, and ensure 211 information is current. Hot line and 211 response should support family members and significant others who are dealing with current and potentially eligible individuals.
- Literature should be available in jails, homeless shelters and other places where potentially eligible individuals reside.
- Keep outreach and engagement records to inform subsequent efforts.
- How would you like the assessment and court process designed?
 - Ensure all parties involved in the court process are trained in AOT.
 - Either use the existing Behavioral Health Court or model the approach after the Behavioral Health Court in Contra Costa.
 - Mitigate the effects of the courtroom environment by considering holding the court process in a more normalized environment.
 - Ensure a multi-disciplinary team is involved in the assessment process, to include primary care, substance abuse professionals and peer and family member providers.
 - Ensure the assessment process evaluates the source of the referral in order to ensure the motivation of the referral source and veracity of information provided supports an appropriate referral.
 - Ensure peer provider support and patient rights advocacy is provided throughout the process. Use volunteers if necessary.
 - The presiding judge(s) is critical. He/she needs to be well trained in AOT, culturally competent and compassionate.
- What services would you want emphasized?
 - Provide services in accordance with the minimum standards specified in the evidence based practice of the Assertive Community Treatment Team model.

- In addition to mental health treatment and case management services provide housing first, ensure peer and family member supports throughout, quality health care, substance abuse assessment and services, and attention to addressing developmental disability issues.
- Services need to be trauma informed and culturally and linguistically competent.
- Staff need to be experienced in connecting to what motivates an eligible individual in order to establish treatment goals and plans in which the individual will actively participate.
- Involve the consumer's family members and significant others in the treatment process as much as is practicable, with emphasis toward mending relationships and developing natural supports.
- Include transition planning to ensure the right level of care is provided at the right time, and the consumer is appropriately connected to lower levels of care as they improve.
- Providers need to continually assess potential harm to consumer, family members and staff, and develop protocols to maximize safety.
- Employ stringent confidentiality measures throughout the process, with care toward minimizing stigma and potential further criminalization.
- Make clear the process by which to opt out of treatment and obtain legal representation.
- Establish stakeholder oversight, and develop clear program and fiscal outcome measures.

Mental Health Services Act (MHSA)
FY 2015-16 Update to the Three Year
Program and Expenditure Plan

OUTLINE OF DRAFT
PLAN

Plan Update for FY 2015-16

Summary

- The FY 15-16 Plan Update proposes to set aside \$43.1 million for fiscal years 2015-16 and 2016-17 to fund 85 programs and plan elements. This is the same total budget as approved last year in the Three Year Plan.
- One new program, Assisted Outpatient Treatment, is proposed.
- The budget indicates that unspent funds from previous years will be utilized for FY 2015-16, but that increased projected revenues for FY 2016-17 will approximate projected expenditures for FY 2016-17.
- It is anticipated that current total budget spending authority will not need to be reduced in order to fully fund MHSA programs and plan elements in future Three Year Plans.

Plan Outline Summary

- Introduction
- Table of Contents
- Vision
- Community Program Planning Process
- The Plan
- The Budget
- Evaluating the Plan
- Acknowledgements
- Appendices
 - Mental Health Service Maps
 - Program and Plan Element Profiles
 - Glossary
 - Certifications, Funding Summaries
 - Public Comment and Hearing
 - Board Resolution

Introduction

- Describes MHSA, MHSA values, statutory and regulatory requirements
- Outlines changes to the Three Year Plan
 - Adds description of this year's Community Program Planning Process
 - Describes the change to regional based Full Service Partnership programs
 - Adds an Assisted Outpatient Treatment program
 - Adjusts Innovation, Workforce Education and Training, and Capital Facilities component budgets to more closely reflect projected expenditures
 - Reflects increased projected revenues to reflect current estimates

Vision

We intend to utilize MHSA funding to assist Behavioral Health Services in addressing three key areas:

- Access – improve assistance with eligibility, transportation, shorten wait times, increase availability after hours, provide services that are culturally and linguistically competent
- Capacity – take the time to partner with the individual and his/her family to determine the level and type of care needed, coordinate necessary health, mental health and other needed resources, and then successfully work through challenging mental health issues
- Integration – work with our health, behavioral health and community partners as a team to provide multiple services coordinated to a successful resolution.

We need to continually challenge ourselves to improve our response to individuals and their families who need us the most, and may have the most difficult time accessing care.

Community Program Planning Process

- Describes the process
- Describes the Consolidated Planning and Advisory Workgroup and ongoing stakeholder participation
- Describes the Community Program Planning Process for FY 2014-15 and FY 2015-16 separately

Community Program Planning Process for FY 2015-16

- Formatted according to the February 25 Community Forum
- Includes online input and summary input from Community Living Room Partnership conversations
- Updates and prioritizes last year's identified needs
- Adds emerging needs and strategies to meet those needs
- Includes input on implementing an Assisted Outpatient Treatment program

The Plan

- Community Services and Supports (CSS)
 - Full Service Partnerships
 - General System Development
- Prevention and Early Intervention (PEI)
 - Reducing risk of developing a serious mental illness
 - Preventing relapse of individuals in recovery
 - Reducing stigma and discrimination
 - Preventing suicide
 - Early intervention
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technology (CF/TN)

Each component leads with a short description of the component and categories within the component, and then lists and describes each program or plan element, cost allocated, and number to be served.

Community Services and Supports

\$31 million to fund:

- 29 MHSA programs that provide services to approximately 2,000 consumers; children who are seriously emotionally disturbed, transition age youth (TAY), adults and older adults who are seriously mentally ill.
- Seven additional plan elements that support and enhance non-MHSA funded community mental health programs and clinics.
- Programs and plan elements include:
 - 9 Full Service Partnership programs (children, TAY, adults)
 - Assisted Outpatient Treatment Program
 - Miller Wellness Center (mental health)
 - Hope House (transitional residential center)
 - Housing Services (temporary, supported or permanent)
 - 3 Wellness and Recovery Centers
 - Older Adult Program
 - Clinic support
 - Administrative support

Prevention and Early Intervention

\$8 million to fund:

- 28 MESA programs that provide prevention and early intervention services designed to prevent mental illness from becoming severe and debilitating, and to provide outreach and engagement to underserved populations.
- Approximately 13,000 individuals served yearly.
- Programs and plan elements include:
 - 8 agencies outreaching to underserved communities
 - 5 agencies supporting at risk youth
 - 5 agencies supporting families with at risk children
 - 3 programs integrating primary and mental health care to adults, older adults
 - First Hope program to provide early intervention for first break psychosis
 - Putnam Clubhouse to assist in preventing relapse
 - Contra Costa Crisis Center and countywide suicide prevention efforts
 - Office for Consumer Empowerment

Innovation

\$1.7 million in FY 2015-16 and \$1.9 million in FY 2016-17 to fund new or different patterns of service that contribute to informing the mental health system of care as to best or promising practices that can be subsequently added or incorporated into the system.

- 5 projects are in operation, and will be throughout the Three Year Plan:
 - Support for lesbian, gay, bi-sexual, transgender or questioning consumers
 - Addressing perinatal or post-partum depression
 - Post-traumatic stress disorder groups
 - Outreach to exploited youth
 - Vocational services for unserved consumers
- 3 projects are in various stages of approval, and will be in operation during the Three Year Plan:
 - Peer wellness coaches
 - Support for the frail, homebound older adult
 - Overcoming transportation barriers to accessing services
- MHSOAC approval needed for each Innovation Project

Workforce Education and Training

\$450,000 annually from Contra Costa's MHSA Fund to recruit and retain a diverse, qualified workforce capable of providing consumer and family driven services that are compassionate, culturally and linguistically responsive, and promote wellness, recovery and resilience across healthcare systems and community based settings. Categories are:

- Workforce staffing support
- Training and technical assistance
- Mental health career pathway programs
- Internship programs
- Financial incentive programs

Capital Facilities and Information Technology

This component enables counties to utilize MHSA funds on a one-time basis for major infrastructure costs necessary to implement MHSA services and supports, and to generally improve support to the County's community mental health service system.

- \$6 million to build and integrate Behavioral Health Services' Epic Tapestry electronic records system with the Epic system currently in use by the County's Health Services
 - \$1.9 million budgeted for FY 15-16
 - \$1.2 million budgeted for FY 16-17

The Budget

Provides estimated available funds, revenues and expenditures by component for each of the three fiscal years. Depicts estimated funds available by component starting July 2017.

NOTE: This current draft version contains dollar amounts that are approximate. This is because Finance is in the process of finalizing the Funding Summaries that will be included as Appendix E. The Budget in the Plan Update needs to match the Funding Summaries, and will be adjusted accordingly.

Budget Analysis

- Indicates expenditures will exceed revenues for FY 2015-16. However, revenues are estimated to approach expenditures for FY 2016-17, thus moving toward a structurally balanced budget for the next Three Year Plan.
- Lists MHSA funding constraints for each component.

Evaluating the Plan

- Describes the implementation of a program and fiscal review process with written report to determine whether MHSA funded program or plan elements:
 - Meet the letter and intent of MHSA
 - Support the needs, priorities and strategies identified in the community program planning process
 - Meet agreed upon outcomes and objectives
 - Are cost effective
- Adds a MHSA financial report to enable ongoing fiscal accountability.

Acknowledgements

A thank you to individuals who shared their stories, provided input, and who are working to make the system better.

Mental Health Service Maps

Provides six one page pictorial of all Contra Costa Mental Health's services broken down by the following:

- East County adult, older adult and transitional age youth
- East County Children's
- Central County adult, older adult and transitional age youth
- Central County Children's
- West County adult, older adult and transitional age youth
- West County Children's

Program and Plan Element Profiles

Provides a profile of each MHSA funded program or plan element according to the following outline:

- Organization contact information
- Brief organization description
- Title(s) and brief description(s) of MHSA funded program or plan element (hyperlinked to Plan)
 - Total MHSA funds allocated
 - FY 13-14 outcomes

Note: FY 2013-14 updates and outcomes are still being received from programs

Glossary

Provides an alphabetical listing and definition of 75 terms used in the document.

Certifications, Funding Summaries

- County Behavioral/Mental Health Director Certification
- County Fiscal Accountability Certification
- MHSOAC required funding summaries

Public Comment and Hearing

- Will include evidence of public comment period and summary of public comments.
- Mental Health Commission's review of draft plan and recommendations.
- Contra Costa Mental Health's response to public comments and Mental Health Commission recommendations.
- Board of Supervisor Resolution

Timeline

- **10APR** - 2D DRAFT Plan Update posted for 30 day public comment period
- **14 MAY** - Mental Health Commission (MHC) hosts Public Hearing on Plan Update
- **21MAY** – Public Comment and MHC recommendations addressed
- **28MAY** - Plan Update submitted to County Administrator for inclusion on Board of Supervisors' (BOS) agenda
- **9JUN** – Earliest date on BOS agenda

Input on DRAFT MHSA FY 2015-16 Plan Update is Welcome!

Point of Contact:
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CPAW Meeting Calendar

April 2015

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8 Systems of Care: 10am—12 pm 1340 Arnold Dr, Ste 200, Martinez	9 Children's: 12:00—1:30pm, 1340 Arnold Dr, Ste 200, Martinez	10	11
12	13 Membership: 3-5pm 1340 Arnold Dr, Ste 200, Martinez	14 Social Inclusion: 10am -12pm 2425 Bisso Ln, Concord	15 Housing: 9-10:30am 1340 Arnold Dr, Martinez	16 Steering: 3-5pm 2425 Bisso Ln, Concord	17	18
19	20 Innovation: 2:30-4:30pm 1340 Arnold Dr, Ste 200, Martinez	21	22 Aging and Older Adult: 2-3:30 pm 2425 Bisso Ln, Concord	23	24	25
26	27	28	29	30		