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

Summary

The first stakeholders meeting for the planning and implementation of Mental Health Services Act (MHSA) was held in Sacramento on December 17, 2004. Approximately 600 stakeholders attended, representing a wide spectrum of stakeholders. This stakeholder process is a consultative process in which the State Department of Mental Health (DMH) is seeking input, not a consensus nor to make decisions as a large group. The State is seeking to find balance between sufficient input and moving the process forward in the planning process. There is a limited amount of time and resources: if we are doing one thing, we cannot do another. The more detailed the process, the longer it may take. DMH is particularly concerned about cultural competence throughout the entire initiative. It is seeking suggestions to help make process more inclusive and welcoming.

After introductions and dissemination of basic information and a brief question and answer session, the large group divided into smaller groups at tables, generally with a mix of different types of stakeholders from different locations, to discuss the MHSA vision statement, planning process, funding priorities and funding process. DMH provided a number of documents to which the participants were asked to specifically respond, noting both the level of approval amongst the people at the table and any comments that might modify the section.

Approximately 460 people, working at 54 tables participated in the table discussions. The largest groups where representatives from county agencies, mental health providers and family members (21% each), followed by advocates (19%), followed by consumers (17%). There were also representatives from state agencies, local mental health boards, the legislature, law enforcement, organized labor and other statewide organizations, as well as schools, consultants and other.

Participants were also asked to answer these questions individually in writing. Individual written comments were provided by more than 260 people, in four formats: answering specific questions (approximately 250 people), providing their own additional feedback at the time and by email soon after the meeting (about 50 people providing over 120 comments), and posing questions during registration (about 20 people providing over 40 questions). The responses are summarized below and details of the table discussions and written comments are attached.

A. Vision Statement Input

After introductions the meeting quickly started to evaluate the vision statement. Most of this feedback was provided in written form, on the *Individual Feedback Form* and on the *More Thoughts Form*.

DMH also provided addresses for e-mail and written comments:

mhsa@dmh.ca.gov

1600 9th Street, Room 130, Sacramento, CA 95814
Attn: MHSA

Comments:

Participants provided both written and verbal comments about the vision statement. About 260 people provided about 380 written comments, many making more than one comment. The major themes were, in order of the number of comments per theme:

- Populations/Consumers and Family
- Children
- Alternative Treatments/Support Services
- Integration with Primary Care
- Workforce/Training
- Cultural Competence
- Outcomes/Quality of Life
- Prevention and Early Intervention
- Vision Statement Process Issues
- Best Practices/Seamlessness/Transformation
- Stakeholders/Collaboration/Criminal Justice
- Substance Abuse/Co-Occurring Disorders

Below is a brief description of key themes and specific verbal comments, with some representative comments. A more thorough description is attached as *Attachment 1 – Individual Feedback* and in *Attachment 2 – More Thoughts*.

Populations/Consumers and Family

This area covered a wide range of concerns. Respondents were concerned that consumers and family members be included in decision making and input; raised issues of family members in disputes with consumers; expressed concern about reaching the unserved, often suggesting broadening the definition of the target populations. Several expressed concern that the definition of the target group be enlarged to include people above 200% of poverty, because mental illness can render people poor quickly and private health insurance does not always adequately cover mental illness. Reaching the homeless population (and ending homelessness entirely) was a concern of others.

People raised issues about DMH's understanding of the client culture, such that providing feedback in a large meeting is challenging to consumers.

- First paragraph: after seniors, add older adults to include folks in their 80's to 100.
- At table, need line on document for older adults.
- Page 2, first bullet: Participation should be described as meaningful. Add involvement in implementation as well as planning.
- Timelines: for counties that do not yet have client base to give input, how can this happen in this short a time? Counties need to get the clients to forums to give input. Client network is holding a forum in January, at which a significant part will be oriented toward MHSA. Can counties use planning money to send clients to forum? Will talk more about this.
- People should stop thinking that consumers should be volunteers to protect SSI; there are many ways for consumers to work and get paid for their expertise. Pay for all expertise!

Children and Youth

Many people were particularly concerned about the needs of children, transition age youth and foster children. Some wanted more definition of the terms and ages considered, most of those seeking the widest age range possible for transition age youth (14-25 generally). Some were particularly concerned that foster youth were being squeezed for services and others were particularly concerned about the collaboration with schools.

- K-12 stakeholders are not mentioned in the list of stakeholders in the requirements for county planning. We need immediate and effective referral systems to get families needed services. Education deals with mental health issues and identified children need to get services to prevent future problems.
- Glad to see focus on transition-age youth. Concern about how defined. What is the vision of transition age – where is cut off? Typically 14-25, but no decisions.

Alternative Treatments/Support Services

This theme incorporates both the inclusion of alternative treatments and modalities and the strengthening of support services such as employment, training, money management, housing, transportation, in-home support, as well as using a holistic approach. The call for specifically including employment assistance was by far the largest group, followed by an emphasis on housing, including long-term, transitional and immediately following release from a hospital as well as board and care facilities.

- Under MHSA component System of Care (SOC), there must be room for non-traditional treatments. Although I received services from Mental Health, they did not help. I talked with other consumers, who agreed we need to use all the resources that we can. Some of cheapest resources are people who have gone through programs and have found that non-traditional programs work. We should pay for planning so that ideas can be included before the programs begin.

- Encourage use of consumer providers, who should be given a stake in the “new world order”. Let us not forget who the system is for.
- Nevada County MH Peer Empowerment Center is a client-run, safe place for clients to go. This should be a model, which is affiliated with Mental Health, but empowered.

Integration with Primary Care

Integration of mental health services, especially with primary care, but also with substance abuse and, to a lesser extent, the criminal justice system, was a common theme. Respondents believed that this integration would increase access while minimizing stigma. Some expressed a concurrent concern that medical practitioners receive adequate training in mental health, especially in medication management.

- There is tremendous value in integrating services for mental health, physical health and substance abuse all together. People are less likely to be deterred by stigma when they can get their mental health care in primary care setting. There are likely to be savings as well.
- The component of prevention and early intervention not highlighted strongly enough, nor is integration in primary care setting. When primary care providers refer out, only 10% of consumers follow up. Integration is critical.
- Glad to see focus on education, because integration is important. Insert the word “seamless,” meaning able to get services in various counties.
- Like the statement about service coordination. When an older adult goes to hospital and cannot advocate for themselves, things to do not work.
- Looking forward to shared housing and educational outings.
- Hope that capital facility money will be matched and used to address housing shortages.

Outcomes/Quality of Life

This theme covers all aspects of evaluation and measurement of outcomes. Respondents expressed concerns that there was not enough mention of these issues. Several suggested specific measures, while others urged the use of independent audits of outcomes.

- Need to look at outcomes rather than programs. There is less conflict when willing to look at outcomes:
    - Safe living arrangement
    - Meaningful way to use one’s time
    - Supportive relationships
    - Ability to get assistance needed, weather crises
    - Physical health
- In addition to reducing adverse impact of untreated mental illness, reduce the negative impact of mental health treatment (i.e., abuse, rights violations, medication side effects, malpractice, etc.).

Vision Statement Process Issues

Several respondents pressed for a shorter version of the vision statement that would be easier to read and more inspiring. Others felt that it was not a visionary statement, but in fact, more “business as usual.” Yet others thought it was too ambitious, and others wanted more definitions, for such things as “supplanting” and “innovation”.

- Functional, utilitarian – needs inspiration, a poetic concatenation and raising central call to service
- Commend the authors for the first paragraph of the vision statement.
- Somewhat disappointed in the vision statement. MHSA has more to appeal to whole community. Would like preamble about general rights, etc. Need to be in language that will appeal to everyone, this is not in vision statement.
- Purpose is to keep people off the street and out of hospital.

Other

A large proportion of the written comments fell into the “other” category: not enough people to qualify as a major category, but still important to include. Themes included collaborations especially with criminal justice, substance abuse and other co-occurring disorders (especially that there is more to dual diagnosis than substance abuse), local capacity and control, whether services should all be voluntary or not (most who mentioned it thought they should be, but by no means all). Many respondents were concerned that there was not enough mention of best practices and evidence-based treatment, which many perceived to include seamlessness and transformation of the system. Some were concerned that mobility between counties had not been addressed, while others just said, yes, they agreed. Others named additional stakeholders they thought should be included.

- There are problems with the way the vision is being developed. A major problem in mental health is warehousing, which has to be transformed into system that works in a different kind of way. It is not addressed in this statement. Tennessee has a program to do this transformation.
- It is important to address mobility because 15,000 foster children are placed out of county. Vision statement and planning for innovative programs need to address this.
- The issues of stigma are very serious: the statement needs far stronger language pointing out that discrimination is not acceptable.
- While the vision statement has mention of trying to improve the mental health–substance abuse link, but there are other dual conditions for which access is an issue. For example, many Alzheimer’s patients also develop mental health symptoms and access for them is not easy. They – and other co-occurring conditions and populations should be included. SB 639 addresses this and its recommendations should be included.
- The vast majority of clients have trauma and post-traumatic stress disorder (PTDS) history. This should not be ignored.
- Page 2: include and utilize the advocacy position papers from the various groups, such as NAMI, UACC, CA Network of Mental Health Clients, etc.

- Concerned about not getting documents early enough. Need information about other documents used to help shape the vision statement like President's Commission Report
- First bullet uses old language: funding driven, specific categories. Using words like SMI, not using voluntary services: these things do not transform the system. In honor of AB34 program, add voluntary every time we use programs and services.
- Planning is a competitive process: for counties with so little resources, it makes it difficult to repeat.
- You must address the issue of criminalization of the mentally ill. It is notably absent from the mission statement.

C. Requirements for Counties to Get Funding for their Public Planning Processes (Attachment C)

A major part of the day was spent discussing the requirements for counties in preparing their request for funding for the initial planning process. Each of the 54 tables was given a form to identify themselves in terms of what stakeholders were represented and then a list of questions relating to the different requirements. This form was also used to denote the level of agreement amongst the participants at each table (All, Most or Some Agree with relevant section), with space for comments. The level of agreement for each section was high, as was the number of comments modifying each section.

Before the groups began their deliberations, DMH staff laid out the issues relating to the planning process requests and answered initial questions.

Basic Process for Implementation

There are six components to implementation of the MHSA:

1. Local planning process
2. System of Care (children, adults, older adults)
3. Capital facilities and technology
4. Education and training
5. Early intervention and prevention
6. Innovation.

There are seven stages to complete for each of the components:

1. DMH develops drafts
2. Stakeholders provide input
3. SMH revised and issues requirements
4. Counties (and cities?) conduct their planning process and submit plan to DMH
5. DMH reviews and approves local plans
6. Counties implement plan
7. DMH provides oversight and accountability

DMH will focus on the overall issues within each component and may develop some shorter term strategies apart from the overall planning effort.

Issues for the Public Planning Process

- What things do we want to see in counties' planning processes?
- What must counties be required to do as part of their planning process?

Questions, Answers and Comments (in Large Group)

Q. Grid – do 7 stages refer to time periods?

A. Some stages will take longer than others.

Q. How do you calculate the homeless with mental illness in terms of financing and distribution?

A. DMH has prevalence information on its website based on census data. Please refer to that information.

Comment. Things need to be turned around. Client should be at center, mental health staff should then be included with them. It is sometimes hard for consumers' voices to be heard.

Q. Will there be some kind of standardization as people move from county to county, taking into consideration the mobility of the populations?

A. Issue of mobility is one we hope to make progress on, including adults, foster youth, students, etc.

Q. Who has the final say at the county level? Board of Supervisors? Mental Health Board or Commission (MHB/C)?

A. Plans are submitted by county Mental Health. With SOC, there needs to be a hearing by local Mental Health Board. Where DMH provides money and contract, responsibility is with county mental health.

Table Discussions
The table discussions discussed these issues thoroughly. Tables were asked to comment on each section of Attachment C, Required Content of County Requests for Funding for the Mental Health Services Act Planning. A detailed description of their comments is attached in *Attachment 3 – Session #1 Group Feedback.* Below is a summary of that feedback.

Section A. Planning must include consumers and families. Most tables (72%) showed agreement for all participants, while 19% showed agreed from most and only

9% showed agreement from only some. The theme which garnered the most comments concerned process issues, such as a lack of requests for evaluation, lack of description of how media and the education process and mechanisms would work, and how school involvement would occur. The next most frequently identified theme was diversity, which addressed both cultural and linguistic competence and the people who would require it in their participation in the process. Consumers and their families were also a key issue, with concerns about inclusion in the process. Outreach was raised as a concern, especially reaching those hard to find, including the homeless and homebound. Many tables were also concerned about definitions and making sure they were clear to all. Specific concerns were raised about youth and older adults (especially now that the Baby Boomers are approaching that designation) and the underserved and unserved, other stakeholders, incentives for participation, funding to get the process started, and technical assistance.

Section B. Planning process must be comprehensive and representative. For this section, most tables noted unanimous agreement with content (66%), while 24% noted that most people at the table agreed and only 10% noted that only some agreed. Concerns were raised about a range of stakeholders, with calls for broadening the circle to include businesses, unions, advocates, neighborhood groups, faith-based groups, education, consumers and their families, community-based organizations, mental health providers and other local agencies. There were a number of concerns raised about the process and documentation of it, both of the meeting and of the planning process as a whole. Other issues and stakeholders mentioned were older adults and their networks, housing, law enforcement, physical health providers, and integration of services.

Section C. There must be clear organizational responsibility for the planning process. In this section, 82% of the tables noted unanimous agreement, with only 18% noting most or some agreed. The table discussions brought up issues with the process, with the counties' role, assuring accountability and responsibility, use of consultants, the State role, and consumers' roles.

Section D. Planning process must be adequately staffed to be successful and inclusive. For this section, most tables noted unanimous agreement with content (74%), while 21% noted that most people at the table agreed, and only 5% noted that only some agreed. The primary concerns raised included staff knowledge and skills, stakeholders, consumer roles, resources, barriers, training, use of consultants and access to technical assistance, funding, and other staff qualifications.

Section E. Full participation requires adequate training in advance. For this section, most tables noted unanimous agreement with content (76%), while 13% noted that most people at the table agreed and only 5% noted that only some agreed. The primary themes were the target population of the training (mental health providers, consumers, school staff and others), training topics (content, process, and diversity), training issues, trainers (expanding to include consumers and families, as well as others), timing issues, definitions, and the State role in training.

Written Feedback

There were a number of written comments on the *More Thoughts Form*, detailed in *Attachment 2* about these principles. Some comments that do not appear elsewhere include:

- Ethnic communities may find it awkward to speak up at large group meetings. Stakeholders from ethnic communities may be more comfortable in small groups with bilingual or interpretive assistance.
- Consumer sessions should be at times that consumers are not working. Many work in the fields from sun up to sundown and can't make a meeting in the middle of the day. Some counties take this direction so they don't receive input.
- How is the federal government involved in the MHSA?
- How will managed care plan a role in the MHSA?

D. Principles for County MHSA Planning Allocation

Issues about the Planning Allocation

- How should DMH distribute $12 million planning money (and only the planning money) statewide? Minimum proposed allocation for each county is $75,000.
- In the DMH proposal, counties would get their proportion of additional money based on prevalence of severe mental illness (SMI) in the county as defined by a prevalence study based on 2000 Census data. Should other criteria be considered?
- Should counties be able to start spending any of the planning money as of January 1, 2005 without a developed or agreed upon plan and approval by the State?
- SOC Plan Requirements are not currently available; they should be out in the next month or two.
- Do you agree with the proposal for the allocation of planning money?
- Is minimum base and additional based on need acceptable?
- Should allocations be proportional to county size?

Questions, Answers and Comments (Large Group)

In addition to the written comments from the tables and individuals, some comments were made to the entire group:

Q. Is it possible to count the mentally ill in the jails for the allocation?

A. Not in the short run. Proposed methodology is based on statistical prevalence of mental illness per county. It is the statistical data base of who may need services, not who is getting services.

Q. What does 200% of poverty level really mean? How does that figure with prevalence of SMI?

A. 200% of poverty is the figure we use for people who generally come to the public system. It includes Medi-Cal and the working poor.

Q. Within 200% poverty population, how have you gotten a count of minority people served?

A. Counts are not based on people served, but on census and mental illness prevalence data. It is not about who is accessing care, but about who may need care. Prevalence data are national research data. SMI and SED are both included in prevalence data.

Q. Can counties get their base first and remainder later?

A. No money is available until about March or April.

Suggestions:

- Would it be possible for formula to add in a factor for ethnic minorities as an underserved population?
- How about allowing a January discretionary fund for mental health programs which would allow monies for staff to attend round of conferences, trainings, etc. that are coming up this Spring?
- Berkeley has its own mental health program (one of two city programs). Should allocation include city programs or only go directly to counties?
- In terms of mobility of population: how do you reflect this? What about big state hospitals and where they are located?

Comments:

A large number of comments were made about the criteria and funding allocations. They are summarized below, by theme. These themes will be echoed throughout the feedback.

Consumers

- I am concerned about people who do not meet allocation method population: they should still be able to access care. I have never met a rich mentally ill person. The whole issue of looking at how funding is distributed is really important. There is such a large undocumented, uninsured population. Perhaps the number of uninsured in county would be a better variable or maybe a combination of poverty and uninsured.
- Make sure underserved consumers are at the table.
- Encourage access to underserved.
- Fund transportation, child care, meals for consumers. Provide lodging if people have to travel far. Provide stipends for consumers as experts.
- Provide funding to purchase of computers at self-help centers. Help eliminate the digital divide.
- Provide peer support assistance for people with dual disabilities.
- Have fairs at counties to help train people.
- California Network of Mental Health Clients is having Jan. meeting and will be doing training.
- Pay consumers for work.
- Frustrated with process of this meeting. Not inclusive for clients. We need to reach clients that are not here: youth, people in institutions, jails, people with English as a second language, homeless, people at risk. Clients should be the ones who are leading the way, writing the documents, etc. There was not enough time to read documents, no advance notice to prepare ahead of time. Are we expected to just go along with everything? This doesn't feel inclusive.

Cultural Competence

- On November 16, 19 family members graduated from Familia a Familia. Feel strongly that underrepresented, particularly ethnic minorities should be encouraged to provide input. Familia a Familia classes should be expanded, money should be provided to people who want to take classes. Have to educate the families about resources that are available.
- Cultural competence is one of the most important issues.
- Cultural competence needs to be embedded throughout
- Stigma needs to be addressed.
- OAC needs ethnic representation.
- Need for creation of bi-lingual, bi-cultural process.
- Develop evidence based practices for ethnic groups
- This is a once in a lifetime opportunity for DMH to show leadership role in area of cultural competence.

Transformation

- Human Cooperative – Excitement is in transformation
- Community means everyone has a place.
- Bringing new people in makes for transformation. Need to bring in people that are not currently involved – involve whole community

Children/Schools

- In terms of creating change, look past special education in schools, there is an infrastructure in the schools called Student Assistance Programs. Take message to the schools. If we build hope with youth, Prop 63 will last much longer.
- One of most important components is with schools. Highly trained school staff need to be involved in this process. Can do a great deal in the areas of prevention and early intervention. School resources need to be emphasized and used.

Other

- First – thank DMH for hosting this meeting. Important to get started.
- Is approval required for the plan for planning the process?
- Police brutality is a major issue.
- Need community-based voluntary services. Innovative services are key. Need to look at this in very different way.
- Money should be spent in the planning process.
- Protocol for assessment of underserved populations. Methods for identifying underserved. Subcommittee for evaluating proposals.

Individual Written Feedback

A total of about 220 people provided 340 pieces of input about funding allocations, through the individual feedback forms, More Thoughts form and questions on the registration form. A detailed summary is attached in *Attachments 1 and 2*. By a ratio of nearly 2:1, respondents wanted at least some of the funding to be released as soon as possible, to get the planning process underway. Concerns were raised about how to monitor this funding, even as they requested the funding. A smaller number of people thought the release of funds should wait until a plan, at least a draft plan, is approved.

A large proportion of the respondents (27%) supported the plan for $75,000 base and additional allocation, based on some criteria. A much smaller number did not approve of the methods of allocation, for a variety of reasons.

There was much concern expressed about the criteria for the allocation. Concerns were raised again about the high cost of serving a large non-English speaking population, the high cost of living in the Bay Area, or serving a large homeless population. Small counties were concerned about the expenses of conducting outreach over large distances or in large rural areas. Others were concerned about minimum allocations to smaller counties. Some asked questions about the need for funding for CBOs rather than exclusively for county-run programs, including caps on such funding. Several people were concerned about the need for evaluation and monitoring of the process, including accountability. Questions were asked about financial accountability, both short and long term. One person asked what would happen if, after everything was set up, there is “a mass exodus of millionaires” from the state?

A number of respondents were concerned that Berkeley not be denied access to funding for planning similar to the funding for counties.

E. Workplan Components

Table Feedback

At the tables, participants were asked to discuss the critical components of the workplan and budget to be submitted by each county. There were relatively few comments about the workplan specifically in the table discussions, often because people ran out of time addressing earlier issues, although there was a high level of unanimous agreement (81%). Detailed description of the responses can be found in *Attachment 3*. The main comments focused on allowance for flexibility, the need to have formal agreements with partners, to assure that relevant target populations are included, to research best practices, to use media judiciously, and to make sure there are outcomes. There was concern that a timeline be included, that consumers have a voice and that the State DMH's role be clear.

There was relatively more discussion about budget questions, covered in the same section as the workplan. People identified specific budget categories and raised specific issues, including using a simple format, capping administratively costs, preparing short and longer term financials, and getting the money out quickly.

Individual Written Feedback

Approximately 160 people provided responses to this question, many of them with multiple concerns, for a total of 211 responses, a detailed summary of which can be found in Attachment 1. Of these, 25% agreed to the components without change. Most concerns about **Local Planning** centered either on collaboration among counties or ensuring good stakeholder representation. Children's **System of Care** was a concern to a number of people, as was concern about specific populations not defined by age but by ethnicity, disability or diagnoses. Housing was the most frequently identified issue within the **Capital Facilities** component. Comments about **Education and Training Programs** were widespread, ranging from a call for a statewide anti-stigma campaign to inclusion of consumer providers are trainers and participation of law enforcement. The primary issue for **Prevention and Early Intervention** was to coordinate effectively with the school systems, to reach all children at risk for mental health problems, not just those exhibiting symptoms. There was also focus on a range of at-risk groups, including those affected by violence or other trauma, prenatal exposure to alcohol, or co-occurring substance abuse. The biggest concern about **Innovation** was its definition. Others thought it should be incorporated in all the other components.

Many of the comments provided in the *More Thoughts Form*, detailed in *Attachment 2*, focused on these six components. Comments that did not appear elsewhere include:

- Please work to shut down state hospitals.

- Create credit cards that registered clients can use to select and pay for services. The credit slips will be routed to a state-funded organization for approval and reimbursement. A list of certified services would be created with ongoing client input. An ombudsperson position can be created to handle complaints from service providers and clients.
- There needs to be more counseling and housing support for mental health clients who are mothers or fathers who have had their kids taken away from them. Care should be given that many of these mothers often lose TANF and become homeless, thus becoming doubly traumatized. CPS staff should be sensitive to this situation, help maintain housing, get counseling support.
- Some prevention funds should be used for research.

F. MHSA Stakeholder Input Process

DMH sought input on the format of the Stakeholder Input Process itself, primarily through the group table discussions. Other written feedback was also provided in the More Thoughts Form, completed at the meeting or later, on-line.

Group Table Feedback

A second, somewhat smaller, round of table discussions centered on issues about the stakeholder process itself. The primary themes identified for the stakeholder process are listed below. A detailed description of the feedback is attached in *Attachment 4 – Session #2 Group Feedback*. The questions included:

- How to run a public input process that is effective, that brings us together to share our concerns in a positive way?
    - Meetings in North and South?
    - Regional meetings?
    - Divide into subgroups – based on areas of interest?

- **Communications Methods**, including teleconferencing, use of the web, outreach, use of multiple methods of contact, media and marketing, telephone (with an 800 number), use of existing outlets, surveys, statewide events and regular mail
- **The Process Itself**, including how meetings should be run, information dissemination and coordination, the general process, funding, goals, and timing
- **Regional Meetings**, for which many people were in favor of North/South meetings while some wanted smaller regions (up to five)
- **Consumers and Other Stakeholders**, which included issues of incentives, outreach, broadening the range of potential partners and ways to make the process work
- **State Role**, including oversight, setting standards, providing leadership, and coordination
- **Diversity**, including cultural and linguistic competence, inclusivity of unserved and underserved groups, people with disabilities, client culture and potential resources,

as well as how cultural competence and diversity would or should manifest at further stakeholder meetings
- **Subgroups**, in addition to or instead of regional meetings, to follow the components of the plan and the Act, including focus groups
- **Components of the Plan**, including again subgroups
- **County Role**, especially in terms of reaching the most people who are unserved or underserved or not even yet considered
- **Training** for consumers, families, providers, staff and the general public
- **Best Practices and Their Dissemination**, including research and communication methods

Written Feedback

In a variety of places within the written feedback opportunities, participants raised a number of important questions and issues. One recurring theme was concern that consumers be consulted, that the process be a bottom-up, grassroots process, accompanied by fear that it was not happening.

Some suggestions and comments not appearing elsewhere included the following:
- When hiring a facilitator for this process, please consider using both a state-selected facilitator and a consumer facilitator selected by the CNHMC.
- I think SDMH should hold its meetings monthly in Sacramento; video conferencing could be made available for each county so people who can't make the trip (line staff) would be able to take part in the discussions. I think consistency in meeting place (Sacramento) is important symbolically. Having a central point for information exchange and a vortex for decision making is especially important during this very critical planning phase when standards and guidelines are being established and short turnarounds are essential. Having the meetings in Sacramento also helps stakeholders establish relations with the reps from statewide organizations (like UACC, CCCMHA, Planning Council and NIMH) who will be critical players in offering technical assistance and follow-up conversations between meetings.
- This forum should be duplicated at local levels. Perhaps you can give us the format and slides to present at local levels to communities.
- The Mental Health Director will implement the plan that its planners develop, use the criteria that benefits the State the best. The hoax of the so-called stakeholders meeting shows this to be the truth.

G. Next Steps

- Summary of comments will be collected and typed by Tuesday. If so, will be on web by Wednesday.

- Bobbie Wunsch will be facilitator and will be designing the stakeholder process.

- Next meeting probably mid to late February.

- DMH is trying to establish web subscription service so participants will be notified of information posted on web. Web will be major vehicle for communication.