Special Meeting of the Mental Health Commission
Bylaws Revision
April 6, 2009

1. Call to Order/Introductions
The meeting was called to order by Chairperson Peter Mantas at 5:05 p.m.

Commissioners Present:	Commissioners Absent:
Art Honegger, District V	Clare Beckner, District IV
Dave Kahler, District IV	Supv. Mary Piepho
Peter Mantas, District III	Connie Tolleson, District V
Bielle Moore, District III	
Colette O'Keeffe, MD, District IV	Non-Commissioners Present:
Teresa Pasquini, District I	Dorothy Sansoe, Senior Deputy CAO
Annis Pereyra, District II	Karen Shuler, Executive Assistant to the MHC

2. Public Comment
None.

3. Announcements
Peter announced the Public Hearing scheduled for April 9th has been postponed due to the Agenda not being posted in time to meeting the Better Government Ordinance regulations.

4. Approval of the Minutes from March 30, 2009
Peter said he had not had an opportunity to check the draft of the Minutes, so approval is postponed to the next Commission meeting, April 23rd.

5. Chairperson's Comments – Peter Mantas
- Peter commented on things he said had been going on since the last meeting, saying there seemed to be discussions among mental health administration staff regarding their relationship with himself and Teresa. Peter said it's wearing him down. He said he will wait for a meeting with Dorothy.
- Peter then stated that effective a few weeks ago, Sherry has contracted with Karen to do MHSA work. He said he and Teresa approved this, but if it becomes too much, we may deal with that. Art said if it runs into a problem, we should let them do that. Bielle asked if the Commission hires her. Peter replied that the Mental Health Division hires a contractor to staff the Commission to do Commission work. He went on to say it's a challenge because she needs to keep an arm's length relationship with Mental Health Administration. Peter asked staff if the contract was due to expire June 30th and staff responded in the affirmative. Peter then said the contract was progressing through the system and staff said it had been delayed because of language Peter had asked to be added to the Service Plan.

6. Continue to Discuss/Make Recommendations Regarding Proposed Bylaws Revision
Discussion proceeded on the remaining revisions proposed by the Bylaws Revision Workgroup.

V: 1, 2 Approved as amended.
VII:4 Approved as amended.
A. The Executive Committee will not act on behalf of the Commission. A Special Meeting of the Commission will be called if action is required. Colette asked why the Executive Committee is in existence. Peter said they act at the direction of the Commission. They do not make decisions, and do not take action on behalf of the Commission. Bielle said the term "actions" needs to be clear if it meets and makes recommendations to the Commission. It was suggested that language be added that states "The Executive Committee, after discussion, will forward recommendations to the Commission." This was not approved as additional language.

B. Dorothy questioned the process for appointing the additional members. Peter stated that Commissioners vote for the Chair, so there needs to be trust. A decision was made to vote for the Chair, Vice Chair and members of the Executive Committee annually at the same time. Revisions were made to V:1 and V:2 to reflect this change.
C. The decision was made to delete "C" (Meetings/Actions).
VII:5 Approved as amended.
The Membership/Nominating Committee will not include the Commission Chair. There will be four members – the Vice Chair plus three who are not interested in being the Chair or Vice Chair during their term. Members may recuse themselves if they want to serve. There was discussion about electing mid-term. Dave said it would diffuse effectiveness. The Mission Statement from the previous Bylaws under Nominating Officers (V:1) will be amended and serve as the Membership/Nominating Committee Mission Statement
VII:6: Approved as amended.
There was a question regarding the definitions of Ad Hoc Committees and Task Forces. There was discussion regarding membership on Ad Hocs and Task Forces. County Counsel has stated members must be Commissioners. After discussion, it was decided to remove Ad Hoc Committees and just have Task Forces and hope County Counsel would agree. Dorothy mentioned that in order for a non-Commissioner to be members of Task Forces it has to be spelled out in the Bylaws. Colette asked if there would be a limit on how many members of the public joined a Task Force. She said it could get very unwieldy if many wished membership. Dorothy mentioned it was also unclear how members from the community would be appointed and who would appoint them. Bielle suggested that when a Task Force is formed, the Commission could designate how many can be on the Task Force. That could be in the motion that establishes the Task Force. Dorothy suggested adding "at the discretion of the Commission" following the word "desire."
VII:7 Approved as amended.
Peter explained that Workgroups do not make decisions, but gather information. Bielle asked why they weren't notices as other meetings are. Peter explained that it was to be able to have flexibility in their meeting schedule. Art added that they can meet quickly, if needed. Bielle said she was concerned that there is potential for someone filing a complaint about not being included. She asked if the 96 hour wait required by the Better Government Ordinance would be a problem and Art said it would. Annis added the issues would come to the Commission for discussion anyhow. Peter again said keeping the committees and workgroups to four prevents a majority of the commission to come to a consensus. A Workgroup is gathering information from the Mental Health Administration. The Capital Facility Workgroup is gathering information on the proposed PHF and the use of MHSA funds. The Bylaws Workgroup is revising the Bylaws. It was mentioned that we need to be sure the definition of collecting data doesn't include writing e-mails on behalf of the Commission. Peter again pointed out a questioned e-mail was written by him, an d as the Chair, he has the obligation to ask those questions. Opinion was offered that if a Workgroup is collecting data, communications should not go to the MHA staff without the Commission being in on it. We need to be mindful of how it appears. Peter stated his position is that if we have a workgroup set up, that workgroup should be able to ask questions. Bielle asked if anyone on a workgroup could contact anyone they wanted to. Dorothy responded that anyone can ask for public records. She added, the aforementioned e-mail appeared to be asking for an investigation. Peter said we are here as an oversight. Bielle stated that if we are creating workgroups, not publicly noticed, and are asking for other than public records, there will be complaints. Peter responded that everything is going through Donna, although we don't have to go through Donna, even though it's a waste of her time. Bielle said that above and beyond this current Commission, these Bylaws will be going on to the future, so we should make sure the Bylaws are very clear. Dorothy said the Bylaws will be reviewed by County Counsel so they should be worded carefully. Bielle said that if we have committees established, those committees could form an ad hoc. She asked why not have committees without ad hocs and task forces? Teresa replied that we were moving away from standing committees.

VII:7D: Approved as amended.
Dorothy said the last sentence stating it wasn't necessary to post notices of the meeting may be a problem for County Counsel. Bielle said she would have to go on the record as not supporting this and suggested striking the last sentence. Peter said he thought that was actually not supposed to be there and we missed it, that it had been struck at the last meeting. The Commission agreed to delete the last sentence.
E: Approved as amended.
Strike "The Chair of a Workgroup must be a Commission member." Colette pointed out that it already says members have to be Commissioners, so the Chair would automatically have to be a Commissioner.
VIII: Approved as presented.
Dorothy said this section wasn't necessary. Peter stated we should get the language right and leave it in. It was decided to leave it in.
IX: Approved as amended.
In response to a question from Bielle, Peter explained that these were the former standing committees of the Commission.

A motion as made to adopt the Bylaws as amended.
M-Honegger; S-Pereyra.
Carried unanimously.

Changes made are reflected in the following document.

7. Next Steps
The proposed Bylaws revisions will be sent to Donna to be forwarded to County Counself for review.

8. Adjourn Meeting.
The meeting was adjourned at 7:00 p.m.

Plain, black text = No changes in original text.
~~Red strikethroughs~~ = Proposed deletions of original text.
Bold, yellow highlighted = Proposed changes and/or additions to original text.

ARTICLE I
NAME OF ORGANIZATION

SECTION 1. NAME OF ORGANIZATION
The name of the organization shall be the "Contra Costa County Mental Health Commission."

ARTICLE II
GENERAL PROVISIONS

SECTION 1. AUTHORITY
The Contra Costa County Mental Health Commission ("Commission" hereinafter) was established by order of the Contra Costa County Board of Supervisors on June 22, 1993, pursuant to the Bronzan-McCorquodale Act, Stats. 1992, c. 1374 (AB. 14)**, also known as the Welfare and Institutions Code Section 5604. Additional authorities were bestowed upon the Mental Health Commission by the Mental Health Services Act Section 5800.**

SECTION 2. ROLES AND RESPONSIBILITY
As specified in the Welfare and Institutions Code Sections 5600 and 5800.
~~The Commission shall:~~

~~A. Review and evaluate the community's mental health needs, services, facilities, and special problems.~~
~~B. Review and County agreements entered into pursuant to Welfare & Institutions Code 5650.~~
~~C. Advise the Board of Supervisors and the Contra Costa County Mental Health Director as to any aspect of the local mental health program.~~
~~D. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.~~
~~E. Submit an Annual Report to the Board of Supervisors on the needs and performance of the County's mental health system.~~
~~F. Review and make recommendations on applicants for the appointment of Contra Costa County Director of Mental Health Services. The Commission shall be included in the selection process prior to the vote of the Board of Supervisors.~~
~~G. Review and comment on the County's performance outcome data and communicate its findings to the California Mental Health Planning Council.~~
~~H. Perform other duties as authorized by the Board of Supervisors.~~

~~As part of its duties set forth above, the Commission shall assess the impact of the realignment of services from the State to the County, on services delivered to clients and in the local community.~~

ARTICLE III
MEMBERSHIP

SECTION 1. MEMBERSHIP

The Commission shall consist of fifteen (15) members appointed by the Board of Supervisors, plus one member of the Board of Supervisors and an alternate assigned to be a representative to the Commission. Each member of the Board of Supervisors shall have three (3) members representing his or her district. The specific seat to be assigned to each nominee will be determined by the member of the Board of Supervisors making the nomination.

The following rules shall apply to membership of the Commission:

A. One (1) member of the Board of Supervisors shall be a member of the Commission**, as required by Welfare and Institutions Code Section 5604.** The Board of Supervisors shall also appoint one (1) Supervisor to serve as an alternate member.

B. Pursuant to the Welfare & Institutions Code Section 5604, fifty percent (50%) of the Commission membership "shall be consumers or parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services." **Membership is divided equally among the five (5) districts. However, should Consumer or Family Member commissioners fall below the twenty (20%) minimum per category or fifty percent (50%) total, as required by the Welfare & Institutions Code, applicants shall be considered from other districts, if available.** On this Mental Health Commission, membership shall consist of:

- Five (5) members shall be Consumer Representatives – individuals who are receiving or have received mental health services **in California, preferably in Contra Costa County.**
- Five (5) members shall be Family Members – parents, spouses, **partners**, siblings or adult children of consumers who are receiving or have received mental health services **in California, preferably in Contra Costa County.**
- Five (5) members shall be Members-at-Large – individuals who have experience and knowledge of the mental health system **in California, preferably in Contra Costa County.**

C. The Commission membership should reflect the ethnic diversity of the client population in the County.

D. The composition of the Commission shall represent the demographics of the County as a whole, to the extent feasible.

E. No member of the Commission or his or her spouse shall be:

- A full-time or part-time employee of ~~**the mental health service**~~ **any Contra Costa County department that is directly involved in the provision of mental health services, or who has a potential conflict of interest.**
- An employee of the State Department of Mental Health; or
- An employee of, or a paid member of the governing body of a mental health contract agency.

F. Except as otherwise provided in Welfare & Institutions Code Section 5604(f), Commission members must be eighteen (18) years of age or older and reside in Contra Costa County.

G. Members of the Commission shall abstain from discussing or voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

SECTION 2. RESPONSIBILITY OF COMMISSION MEMBERS

Attendance requirements:

A. Regular attendance at Commission meetings is mandatory for all Commission members. ~~After three (3) absences, the Chairperson may contact the appointing Supervisor for appropriate action.~~ **A member who is absent, whether excused or unexcused, from three (3) Commission meetings in any twelve-month period shall be deemed to have automatically resigned from the Commission. In such event the member's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission's minutes. The Commission Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member's resignation and request the appointment of a replacement.**

~~B. Each member of the Commission shall serve on at least one standing committee of the Commission that meets on a monthly basis. If she/he does not choose a committee, the Chairperson shall appoint the Commissioner to a committee. Attendance requirements are the same as those pertaining to Commission meetings.~~

B. Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the full Commission.

C. The Chairperson may grant a Commission member a leave of absence, not to exceed three (3) consecutive regular monthly Commission meetings. A leave of absence may only be granted when the affected Commissioner requests it. To grant such a leave, the Chairperson shall announce it at a Commission meeting. The leave may become effective at the meeting at which it is announced. The leave waives the limitation of absences stated in Section 2, item A of this article. No more than two leaves of absence shall be afforded to said Commissioner during the Commissioner's term. Partial term appointments will be pro-rated.

SECTION 3. TERMS

The term of each member of the Commission shall be three (3) years in duration. Appointments shall be staggered so that approximately one-third (1/3) of the appointments end each year. All terms end on June 30 in the appropriate year. ~~There are no term limits.~~

No member shall serve more than four (4) consecutive three-year appointments. As of the date of adoption of these Bylaws, any member serving a fourth three-year appointment shall not be eligible for reappointment as a Commissioner. When one year has elapsed following a former member's service on the Commission, of whatever duration that service was, he/she again becomes eligible for appointment.

The member of the Board of Supervisors who is appointed to the Commission shall serve ~~a three-year term~~ **an unlimited** term ~~or~~ until replaced by the ~~Board of Supervisors, on the recommendation of the~~ County Board of Supervisors.

SECTION 4. VACANCIES
The Chairperson ~~is obligated to declare a vacancy and direct the Executive Assistant to~~ **shall** notify the member of the Board of Supervisors who made the appointment and the Clerk of the Board if a Commission member:

A. Resigns;
B. Moves outside the County limits; or
C. Develops a conflict of interest as defined in Article III, Section 1, Subsection H.

~~Additionally, the Chairperson may request that the Executive Assistant notify the appropriate member of the Board of Supervisors if a Commissioner is absent from three (3) meetings during any calendar year (January through November).~~

SECTION 5. FILLING COMMISSION VACANCIES
Each member of the Board of Supervisors is encouraged to involve the Commission in all recruitment and screenings for applicants. Following an interview by the ~~Executive~~ **Membership/Nominating** Committee, the Committee will forward its recommendation to the Commission. After Commission approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for their action.

SECTION 6. COMMISSION RECRUITING PROCESS
In order to comply with Welfare and Institution Code membership mandates, the Commission shall receive applications on an ongoing basis.

ARTICLE IV
MEETINGS

SECTION 1. REGULAR MEETINGS
Meetings of the Mental Health Commission shall be held monthly. A minimum of eleven (11) meetings shall be held per year. If the regular meeting date falls on a holiday, a new meeting date shall be selected.

SECTION 2. ORDER OF BUSINESS
~~A.~~ Agendas shall be prepared for regular Commission and Executive Committee meetings at the direction of the Commission Chairperson**(s)**. When feasible, ~~the Executive Assistant shall mail~~ agendas **shall be distributed** seven (7) days prior to the meeting. Agendas shall be posted, mailed and made available to the public in accordance with the Brown Act and Contra Costa **County** Better Government Ordinance.

~~B. Public Comment will be taken on each item on the agenda, in accordance with the Brown Act and the Contra Costa County Better Government Ordinance.~~

SECTION 3. QUORUM
A quorum shall be ~~a majority of the number of the currently filled seats on the Commission~~ **one person more than one-half of the appointed members**. The Commission must have a quorum present in order to hold a meeting.

SECTION 4. CLOSED SESSION
The Commission may not conduct closed sessions.

SECTION 5. SPECIAL MEETINGS
Special meetings of the Commission may be called at any time by the Chair or by a majority of the members of the Commission in accordance with the Brown Act.

SECTION 6. OPEN MEETINGS
All meetings of the Commission and all meetings of the standing **committees**, ~~subcommittees,~~ task forces **and workgroups** appointed by the Commission shall be open to the public**, in accordance with the Brown Act.**

SECTION 7. DECISIONS AND ACTIONS OF THE COMMISSION
Unless otherwise stated, all matters coming before the Commission for action shall be determined by a ~~vote of the majority of the appointed members present at the meeting~~ **simple majority vote.**

A simple majority vote is defined as the vote of the majority of the appointed members present at the meeting.

An absolute majority vote is defined as a vote of the majority of appointed members and is noted where required.

SECTION 8. ADDRESSING THE COMMISSION

~~Any person wishing to address the Commission shall give their name for the record. The Chairperson may set the total to be allowed for all speakers on any one subject and may limit the amount of time a person may use in addressing the Commission.~~

Public Comment shall be allowed on any items of interest to the public that is within the subject matter jurisdiction of the Commission, both agendized and non-agendized items, in accordance with the Brown Act and the Contra Costa County Better Government Ordinance. **The Chairperson may limit the amount of time a person may use in addressing the Commission on any subject, provided the same amount of time is allotted to every person wishing to address the Commission.**

ARTICLE V
ELECTION OF OFFICERS

SECTION 1. NOMINATION OF OFFICERS
~~The Executive Committee constitutes the Nominating Committee. The Nominating Committee shall select nominees for Chairperson and Vice Chairperson of the Commission, obtain the nominees' consent to serve, and provide the slate of nominees to the Commission at their October meeting.~~

For annual appointment of Commission Chairperson, Vice Chairperson, and members of

the Executive Committee, the Membership/Nominating Committee shall announce the solicitation of nominations from Commission members during the September meeting or the next regularly-scheduled meeting, obtain the nominees' consent to serve, and announce the slate of nominees at the October Commission meeting, or at the next regularly scheduled meeting. Should the position become vacant during the term, nominations will be taken at the next meeting.

SECTION 2. ELECTION
The Commission shall elect a Chairperson**,** ~~and~~ Vice-Chairperson **and members of the Executive Committee** at the **next** regular meeting of the Commission ~~in November~~ **following the announcement of nominations as set forth in Section I.** The newly-elected Chairperson**,** ~~and~~ Vice-Chairperson **and members of the Executive Committee** shall assume office January 1 and serve through December 31 of that year. **In the case of a mid-term appointment, the elected Chair, Vice Chair or members of the Executive Committee will complete the remainder of the normal term.**

The election will be conducted publicly through the use of signed ballots. Ballots will be announced and counted publicly by the Membership/Nominating Committee. The election of each officer will carry with a simple majority vote. In the case of a tie vote, the Membership/Nominating Committee shall hold elections during the next scheduled Commission meeting and the current seated officer will retain office until a new officer is elected.

At the request of the ~~Executive Committee~~ **Membership/Nominating Committee** and upon the approval of the Commission, Co-Chairpersons may be elected.

SECTION 3. REMOVAL
The Commission, by a**n absolute** majority vote, may remove the Chairperson and/or Vice-Chairperson from office and relieve them of their duties. In the event of removal of the Chairperson and/or Vice-Chairperson, the ~~Executive Committee shall meet as the Nominating Committee~~ **Membership/Nominating Committee shall meet** and present nominations for the vacant position(s) at the next regularly scheduled Commission meeting.

ARTICLE VI
DUTIES OF OFFICERS

SECTION 1. DUTIES OF THE CHAIRPERSON
The Chairperson shall preside at all meetings of the Commission and perform duties consistent with these Bylaws**, the Welfare and Institutions Code and the Commission Policy and Procedure Manual.** The Chairperson will be in consultation with the local Mental Health Director.

The Chairperson shall conduct meetings, maintain order and decorum, and decide questions of procedure as required by the Brown Act and the Contra Costa County Better Government Ordinance.

In the event Co-Chairpersons are elected for the Commission, all the duties of the Chairperson will be divided between the Co-Chairpersons and all references to Chairperson herein will apply to the Co-Chairpersons.

The Chairperson shall appoint a representative, who may be either an officer or other member of the Commission, to the California Association of Local Mental Health Boards/Commissions. The duties of the representative to the statewide organization shall be to represent the Mental Health Commission at statewide meetings and to make regular reports to the Commission.

The Chairperson may not serve as a member of the Membership/Nominating Committee.

SECTION 2. DUTIES OF THE VICE CHAIRPERSON
In the event of the Chairperson's absence from a meeting of the Commission or inability to act, the Vice Chairperson shall preside and perform all duties of the Chairperson. In case of removal of the Chairperson, the Vice Chairperson shall perform all duties of the Chairperson until new elections can be held.

SECTION 3. TEMPORARY CHAIRPERSON
In the event both the Chairperson and Vice Chairperson are absent from a meeting of the Commission or unable to act, the members shall, by order fully entered into their records, elect one of their members to act as Chairperson Pro Tem. The Chairperson Pro Tem shall perform the duties of the Chairperson until such time as the Chairperson or Vice Chairperson resumes his or her duties.

ARTICLE VII
COMMITTEES

SECTION 1. CREATION OF COMMITTEES
Pursuant to the rules set forth herein, the Commission may create committees ~~as needed, including but not limited to standing committees, subcommittees and task forces.~~ **which can be standing committees, task forces or workgroups as needed**. **No more than four (4) Commission members should be appointed to any committee.**

~~Standing committees may be created by the Commission on its own motion. Subcommittees may be created by the Commission on the recommendation of a sponsoring standing committee. Task forces may be created by the Commission on its own motion or upon the recommendation of a sponsoring standing committee.~~

SECTION 2. STAFF ASSISTANCE ~~TO COMMITTEES~~
The staff of the Contra Costa County Mental Health Division shall serve in an advisory capacity to committees of the Commission. The Executive Assistant to the Commission will provide staff support to all committees.

SECTION 3. STANDING COMMITTEES
A. Mission Statement

Each standing committee shall develop a Mission Statement. The Mission Statement is subject to approval by the Commission, and shall be submitted to the Commission for approval no later than 60 days after establishment of the committee. The standing committees may include, but are not limited to, the following:

~~1. Adult & Transitional Age Young Committee~~
~~2. Children's Committee~~
~~3. Executive/Finance Committee~~
~~4. Justice System Committee~~
~~5. Older Adult Committee~~

1. Executive Committee
2. Membership/Nominating Committee
3. Other Standing Committees as established by the Commission

B. Membership

~~With the exception of the Executive Committee,~~ **T**he membership of each standing committee shall include a minimum of two (2) **and a maximum of four (4)** members of the Commission.

C. Appointment and Terms

1. The Commission Chairperson may appoint Commission members to standing committees **in accordance with the Commission's Policy and Procedures Manual.**
2. The terms of the Committee Chairpersons and Vice Chairpersons shall be one (1) year. There are no limits on the number of terms an individual may serve as Chairperson.

D. Meetings/Actions

1. All matters coming before a standing committee shall be determined by a majority of the Commission members voting, subject to approval by the Commission.
2. All standing committee meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance. ~~With the exception of the Executive Committee, two (2) members of the Commission shall constitute a quorum for the transaction of business.~~

E. Chairpersons/Co-Chairpersons/Vice Chairpersons

1. Selection
   1 Each standing committee shall have a Chairperson and may have a Co- or Vice Chairperson. Chairpersons and Co- or Vice Chairpersons of standing committees must be Commission members. They are selected by the Commission Chairperson, subject to approval by the Commission.
   2 In the event of a vacancy in the position of Chairperson of a standing committee, the Commission Chairperson may serve as temporary Chairperson of the standing committee for up to ninety (90) days. If the position remains vacant for more than 90 days, the standing committee shall go into abeyance until a Chairperson is appointed.
2. Duties
   1 The Chairperson shall preside at all meetings of the standing committee and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall be in consultation with the Commission Chairperson.
   2 The Chairperson shall direct the preparation and distribution of agendas for the standing committee.

3 The Chairperson shall provide monthly reports to the Commission regarding the activities of the standing committee, and is encouraged to provide an outline of the monthly report to the Executive Assistant to the Commission for use in preparation of the Minutes.

4 The Chairperson shall conform to the Mental Health Division client confidentiality statement and ensure that members and attendees of the standing committee do likewise.

~~F. Executive Committee~~

1. ~~Members of the Executive Committee shall include, but are not limited to the Commission Chairperson, Co-Chairperson (if any), and Vice Chairperson and the Chairpersons, or their designees (who must be Commissioners), of each standing committee.~~
2. ~~At the request of the Commission Chairperson, the Commission may authorize the Executive Committee to act in place of the Commission.~~
3. ~~One (1) person more than half the specified members of the Executive Committee, above, shall constitute a quorum. Any and all actions of the Executive Committee are subject to ratification at the next regular meeting of the Commission.~~

SECTION 4. EXECUTIVE COMMITTEE

A. Mission Statement

The Executive Committee is charged with acting on the decisions of the full Mental Health Commission. Its primary focus is to identify and avail any reasonable resources needed to deliberate over agenda items of the general membership, workgroup, committee or task force meeting.

B. Membership

Members of the Executive Committee shall include the Commission Chairperson, Co-Chairperson (if any), and Vice Chairperson. Additional member(s) will be elected by the Commission for a term of one calendar year. The Executive Committee shall consist of a maximum of four (4) members.

SECTION 5 MEMBERSHIP/NOMINATING COMMITTEE

A. Mission Statement

The Membership/Nominating Committee shall interview applicants to the Commission. Following the interview, the Committee will forward its recommendation to the Commission. After Commission approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for their action.

The Membership/Nominating Committee shall also select nominees for Chairperson, Vice Chairperson, and members of the Executive Committee, obtain the nominees' consent to serve, and provide the slate of nominees to the Commission.

B. Membership

Members of the Membership/Nominating Committee shall be the Commission Vice Chairperson and three (3) additional Commissioners. The Commission Chairperson may not serve on the Membership/Nominating Committee. The

Membership/Nominating Committee shall consist of a maximum of four (4) members.

SECTION 6. TASK FORCES

A. Purpose

Task Forces shall be time-limited and have a stated purpose approved by the Commission **and shall be required to report back to the Commission regarding progress toward their stated purpose.**

B. Membership **of Task Forces**

The membership of each task force shall include a minimum of two (2) **but no more than four (4)** members of the Commission who shall serve on the task force as liaisons to the Commission. **Other members may be appointed from the community when special expertise, advice or opinion is desired, at the discretion of the Commission.** All members and attendees shall conform to the Mental Health Division client confidentiality statement.

C. Appointment and Terms

The Commission shall appoint ~~Commission~~ members to task forces upon the recommendation of the ~~sponsoring standing committee, if any, or~~ ~~Executive Committee~~ **Commission**. The terms of all task force members~~, including the Chairperson,~~ shall be ~~six (6) months, or~~ until the task force has completed its mission~~, whichever comes first~~.

E. Meetings/Actions

A minimum of two (2) Commissioners**, or 50% of the membership plus one individual, whichever is more,** shall constitute a quorum for the transaction of business. All matters coming before task force shall be determined by a **simple** majority of the members voting~~, subject to approval by the sponsoring standing committee, if any,~~ and Commission. All ~~task force~~ meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance.

F. Chairpersons/Co-Chairpersons

1. Selection

   Each task force shall have a Chairperson, ~~appointed by the Commission on the recommendation of the sponsoring standing committee, if any, or Executive Committee.~~ **selected by the members of the task force.** The Chair of an task force must be a Commission member. In the event of a vacancy in the position of Chairperson of task force, the ~~sponsoring committee~~ **Commission** Chairperson may serve as temporary Chairperson of the task force for up to 90 days. If the position remains vacant for more than 90 days, the task force shall go into abeyance until a Chairperson is appointed.

2. Duties

   - The Chairperson shall preside at all meetings of the task force and perform his or her duties consistent with the procedures outlined herein. The Chair shall be in consultation with the Commission Chairperson.
   - The Chairperson shall direct the preparation and distribution of agendas for the task force.
   - The Chairperson shall provide monthly reports to the ~~sponsoring standing committee, if any, or~~ Commission.

- ~~The Chairperson shall conform to the Mental Health Division client confidentiality statement and ensure that members and attendees of the subcommittee do likewise.~~

SECTION 7. WORKGROUPS

A. Purpose

Workgroups shall be time-limited and have a stated purpose approved by the Commission and shall be required to report back to the Commission regarding progress toward their stated purpose.

B. Membership of the Workgroup

The membership of a workgroup will consist of a minimum of two (2) but no more than four (4) members of the Commission.

C. Appointment and Terms

The Commission shall appoint Commission members to a workgroup upon the recommendation of the Commission in accordance with the Commission Policy and Procedures Manual.

D. Meetings/Actions

A minimum of two (2) Commissioners, or 50% of the membership plus one individual, whichever is more, shall constitute a quorum for the transaction of business. All matters coming before a workgroup shall be determined by a simple majority of the members-and Commission.

E. Chairpersons/Co-Chairpersons

1. Selection

Each workgroup shall have a Chairperson, appointed by the Commission Chairperson. In the event of a vacancy in the position of Chairperson of a workgroup, the Commission Chairperson may serve as temporary Chairperson of the task force for up to 90 days. If the position remains vacant for more than 90 days, the workgroup shall go into abeyance until a Chairperson is appointed.

2. Duties

- **The Chairperson shall preside at all meetings of the workgroup and perform his or her duties consistent with the procedures outlined herein. The Chair shall be in consultation with the Commission Chairperson.**
- **The Chairperson shall direct the preparation and distribution of agendas for the workgroup.**
- **The Chairperson shall provide monthly reports to the Commission.**

ARTICLE VIII
COMMISSION POLICY AND PROCEDURE MANUAL

A. Purpose

Establish policies and procedure within which the Commission will operate. None of these guidelines can be established to nullify or circumvent these Bylaws, the Welfare and Institutions Code or any other prevailing laws and statutes.

B. Establishment and Amendment of these Policies and Procedures

The Policies and Procedures are established and amended by an absolute majority

vote during a regular Commission meeting.

ARTICLE IX
COMMISSION/MENTAL HEALTH DIVISION RELATIONSHIP

SECTION 1. STAFF SUPPORT
The Mental Health Division shall provide for administrative and clerical support services to manage the operations and activities of the Mental Health Commission. The budget of the Mental Health Division shall fund the position of the Executive Assistant to the Mental Health Commission.

SECTION 2. MENTAL HEALTH STAFF ATTENDANCE AT MEETINGS
The Mental Health Division staff shall provide information to the Commission, or to committees, regarding agenda items and attend meetings on a regular basis. ~~The Commission requests that appropriate staff members or their designees regularly attend the following meetings:~~

1. ~~Adult & Transitional Age Youth Committee – Adult/Older Adult Mental Health Program Chief~~
2. ~~Children's Committee – Children/Adolescent Mental Health Program Chief~~
3. ~~Executive/Finance Committee – Mental Health Director and Health Services Financial Director~~
4. ~~Justice System Committee – Adult/Older Adult Mental Health Program Chief~~
5. ~~Mental Health Commission – Mental Health Director~~
6. ~~Older Adult Committee -- Adult/Older Adult Mental Health Program Chief~~

SECTION 3. ACTIONS
The Commission shall regularly inform the Director of Mental Health Services of Commission actions.

ARTICLE X
BYLAW AMENDMENTS

SECTION 1. AMENDMENTS
These bylaws may be amended by **an absolute** majority vote ~~of the appointed members~~ in a regularly scheduled meeting as defined at Article IV, Section 1. Before the Commission may consider and/or vote on Bylaw amendments, proposed amendments shall be submitted in writing to Commission members at least thirty (30) days prior to the meeting date at which they are to be considered. Amended Bylaws shall be submitted to County Counsel for review, finalized by the Commission and then transmitted to the Board of Supervisors for final approval.

CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION
April 23, 2009

Minutes

1. CALL TO ORDER / INTRODUCTIONS The meeting was called to order by Chair Peter Mantas at 4:35 p.m. Commissioners Present: Commissioners Absent: Clare Beckner, District IV Supv. Mary Piepho Art Honegger, District V Dave Kahler, District IV Peter Mantas, District III Bielle Moore, District III Colette O'Keeffe, MD, District IV Teresa Pasquini, District I Annis Pereyra, District II Non-Commissioners: Suzette Adkins, Supv. Bonilla's Office Eric Cho, Conservator's Office Brenda J. Crawford, MHCC Al Farmer, NAMI-CC John Gragnani, Local 1 / Mental Health Coalition Steven Grohic-McClurg, Rubicon Programs Anne Heavey, NAMI-CC / MHSA Family Steering Committee Victor Montoya, Mental Health Administration Mariana Moore, Human Services Alliance Floyd Overby, MHC Applicant Dorothy Sansoe, CAO's Office Dan Shortenhaus, NAMI-CC Karen Shuler, MHC Staff Connie Steers, MHCC - Patients' Rights Suzanne Tavano, Mental Health Administration Tomi Van de Brooke, Chief of Staff for Supv. Piepho Donna Wigand, LCSW, Mental Health Director Janet M. Wilson, MHCC - Patients' Rights	
2. PUBLIC COMMENT 1) Connie Steers, Patient's Rights, spoke about SSI cutbacks and loss of services to consumers including Dent-Cal, podiatry, vision care and additional cuts. She acknowledged NAMI for helping with food.	
3. ANNOUNCEMENTS 1) April 29: Public Hearing on the MHSA-CSS FY 08/09 Draft Plan Update. 2) May 6: Meeting of the Family Involvement Steering Committee with the MHSA Steering Committee.	

3) Wednesday, May 27, 10 am-3 pm. Disability Capitol Action Day 2009 on the west steps of the State Capitol in Sacramento. 4) Peter made the announcement that Connie Tolleson, Consumer Representative from District V, has resigned the Commission for personal reasons.	
4. APPROVAL OF THE MINUTES **From March 26th Meeting:** A motion was made (**M-Honegger; S-Beckner**) to approve the Minutes as presented. Discussion followed during which a request to have the March 26 Minutes transcribed was made. Peter called for the motion to be amended to adopt as presented, and then get a transcription of that meeting to be available in 30 days. Art and Clare agreed to amend the original motion to accept the Minutes as presented and to add the provision of receiving a transcription within 30 days. The amended motion carried unanimously. **From March 30th Meeting:** A motion was made (**M-Pereyra; S-O'Keeffe**) to approve the Minutes as presented. The motion carried unanimously. **From April 6th Meeting:** A motion was made (**M-O'Keeffe; S-Pasquini**) to approve the Minutes as presented. The motion carried with a vote of 7-0-1 (Beckner abstained).	*Staff: Transcribe March 26, 2009 Minutes by May 23, 2009*

5. REPORTS: ANCILLARY BOARDS/COMMISSIONS
a. Mental Health Coalition & Hospital Community Forum – Teresa Pasquini
• Mental Health Coalition: The Key discussion points were the following:
  • Disconnect of Services for consumers in all age groups.
  • No continuum of care.
  • Treatment Silos creating barriers.
  • Proposed budget cuts may impact Patient's Rights services, which are mandated.
  • Concerns expressed about the lack of action, from stakeholders, to unite and drive strategies for improved, integrated services, based on the intent of the MHSA, which would lead to Transformation of the mental health system. Emphasized the need to inform our members to become more involved in MHSA implementation and push for transparency that would show improved outcomes.
  • Discussed communication barriers and breakdown of partnerships that would improve the above issues. Frustrations and lack of confidence in the process were expressed.
Teresa said she would like to suggest that the Commission consider formulating a position on these issues that she could take into future
	Place discussion of key MH Coalition issues as a

Coalition meetings that would allow them to strategize on solutions. • Hospital Community Forum: Teresa distributed a report from the last meeting of the Hospital Community Forum, held February 12, 2009 and asked that the Commission appoint someone to officially represent the MHC at the Hospital Community Forum. Peter asked for anyone who is interested to contact him. Teresa also distributed an e-mail in which Miles responded to questions posed by a Commissioner, along with a flyer announcing the Forum the second Thursday of each month. **b. Contractor's Alliance – Mariana Moore** Mariana announced that the Contractors' Alliance has changed its name to The Human Services Alliance of Contra Costa, and invited Commissioners to attend an Open House on May 30th from 4:30-6:00 at John F. Kennedy University in Pleasant Hill in celebration of the Alliance's name change and their new "home" at JFK University. Invitees will include county elected officials and staff, community agencies, county commission members, and other community partners. Mariana publicly acknowledged the Mental Health Administration for the PEI grants, saying non-traditional stakeholders have been brought to the table in service delivery who are working in partnership with the county. Mariana added she is also involved in the CPAW. She commended Sherry Bradley for her work and happily noted that Alliance members are at the table. She looks forward to working with them in going forward. The Alliance is also working with Donna on the FMAP issue. **c. Local 1 – John Gragnani** John said he met with [Children's Mental Health Program Chief] Vern Wallace last month and expressed similar concerns to what he has expressed to the Commission regarding the effect of budget cuts on children's services, stating the children's system is at severe risk. He hopes for support through the MHSA Prevention & Early Intervention program. Peter asked if there was anything the MHC or the Mental Health Administration can do to address that. John suggested a dedicated meeting to thoroughly examine the children's mental health system to figure out a way to transform it to meet our community's needs. Peter stated that the Commission will be meeting in a planning session to amend their action plan to address new needs due to budget cuts. **d. Mental Health Consumer Concerns (MHCC) - Brenda J. Crawford** Brenda also complimented Mental Health Administration on the	*possible action item on the May agenda.* *Place assignment of representative on the May Agenda.*

awarding of the PEI grants. She added she would also like to see the family and consumer movement getting more support.

The MHCC has 2 fully-operating centers, and are looking at a facility in Antioch. They are already outgrowing their Richmond center.

Wellness & Recovery Centers (WRC) - MHCC currently has two of its three WRC's fully operating, and it is anticipated that the third WRC in East County will resume operation by May 15, 2009. The combined average daily attendance of consumers at the two WRC's is approximately fifty-five. Recovery/Resiliency based services continue to be the foundational program offering, such as WRAP and men and women's peer support /empowerment groups. In addition new services have been incorporated into the programs that are designed to engage consumers on a spiritual, mental and physical level. These services include weekly Yoga, Tai-Chi and physical fitness classes. In the next fiscal year depending on the budget it is our intention to contract with independent consultants to provide weekly sessions in basic computer skills, anger management, life skills, healthy eating and basic nutrition groups. MHCC again depending on the budget will implement services at all three WRC's that combine clinical approaches with recovery based services to address the diverse needs of consumers in Contra Costa County; groups that focus co-occurring disorders will be offered and facilitated by a trained clinician.

Patients' Rights- the Patients' Rights program of MHCC has been extremely busy since the move to Treat Blvd. The acuity and census at Contra Costa Regional Medical Center has been high, with accompanying procedural issues. There has been a significant number of grievance/managed care issue primarily around requests for change of provider, as well as residential issues including HUD housing inspections. Patients' Rights Advocates continue to assist consumer who live in community housing primarily focused on ensuring that housing repairs are accomplished in a timely manner by the landlords. The MHCC management team and the Patients' Rights department are looking at ways to better monitor board and care homes per Welfare & Institution Code Section 5520[b]. Currently the Patients' Rights contract is under resourced, and the demand for the services exceeds the current staff capacity. In addition MHCC continue to receive calls from consumers who have been placed out of county.

General Overview-MHCC's is Collaborating with the Division of Mental Health & Vocational Services to manage the SPIRIT Training Program, which has had some administrative implementation problems this year. However, the overall training has been successful and the students are now in the work-study portion of the project. The Contra Costa Network of Mental Health Clients is being reorganized and the first meeting will be held by the middle of May. The Consumer

Satisfaction Surveys will be conducted in May and training for survey takers will occur in April.

e. National Alliance on Mental Illness (NAMI) – Al Farmer

NAMI-CC President Al Farmer read this statement to the Commission: "The NAMI Board of Directors is gravely concerned about the deteriorating quality of mental health care and with the plans for a new PHF facility. There is almost no transparency, oversight or accountability. At its monthly meeting on April 11, 2009, the Board of Directors of NAMI Contra Costa shared concerns about the following:

- The stakeholder process has broken down and reverted to business as usual. The consumer and family voices are being ignored. We would encourage the Commission to advise the BOS that the intent of MHSA, which is to value lived experiences of the consumers and their family members, must be respected and reflected in the programs that are funded with MHSA dollars.
- The lack of community involvement in the planning and development of the PHF/Pavilion at 20 Allen is unacceptable. To proceed with a plan that may eliminate the current hospital inpatient unit, without a strong community partnership, which should include NAMI CC, is alarming. This is something that our members were assured would not happen again, when we expressed our outrage, over the closing of Ward 4D. We would encourage the Commission to advise the BOS that the failure to inform and include NAMI CC in this planning process is not keeping in the spirit of community partnership. We are being steamrolled with this PHF project.
- The failure to provide adequate funding of the Community Wellness Centers and Patients' Rights contracts with MHCC must be addressed. The Patients' Rights services are State Mandated and must be maintained.
- The intimidating and critical tone expressed by the Mental Health Director, at the Commission's March meeting, was disappointing. The NASMI CC Board, acting on behalf of our members, had solicited assistance from the MHSOAC, on concerns that affect our community. The Board of NAMI Contra Costa believes that it is our duty to ensure that the programs and expenses of MHSA are in line with the guidelines and have been implemented and maintained in accordance with the Performance Contract with the California DMH. We encourage this Commission to

address the remaining questions and concerns stated by the Family Steering Committee Letter of March 26, 2009. NAMI Contra Costa would never suggest having funds withheld that would benefit any consumer or family in Contra Costa County, or that improve our county's Mental Health System. We do expect, however, that the funds are spent in accordance with the Act and that oversight and accountability are critical to our members to ensure the best possible care for our loved ones. Respectfully Submitted, Al Farmer, President of NAMI Contra Costa On behalf of the NAMI CC Board of Directors."	
6. COMMITTEE / WORKGROUP REPORTS **a. Bylaws Workgroup – Peter Mantas, Chair** 1) Amendments are prepared for County Counsel's Review The finalized amendments are in the process of being forwarded to County Counsel for review. **b. Executive Committee – Teresa Pasquini, Chair** 1) Update on current candidates • Dr. Floyd Overby: Supv. Uilkema's office said that Dr. Overby will be appointed to the District II Family Member Seat in May • Anne Reed: Supv. Uilkema is interviewing Anne Reed Monday for the District II Member-at-Large seat • Scott Nelson: No decision has been made by Supv. Piepho's office regarding appointing Scott Nelson to the District III Consumer Representative seat. **c. Capital Facilities & Projects Workgroup – Art Honegger, Chair** 1) Review responses from MH Director to workgroup with respect to the Psychiatric Healthcare Facility (PHF) requests for information. Art began his report by detailing his personal experiences regarding this issue. **January 22, 2009 – Public Comment Meeting** a) The Capital Facilities Proposal was not amended in any way to reflect the public comment given during this proceeding. It was a charade. b) We were assured upon questioning that the proposed Mental Health Recovery Center was not a done deal (this later proved to be a lie). c) Mental Health Administration assured us that there would be a follow up stakeholder meeting specifically for consumers and families. That was a lie. It never happened.	

January 29 – In my phone conversation with Sherry Bradley, I was assured that there would be a follow up consumer and family focus group. It never happened.
February 9 – In my phone conversation with Suzanne Tavano, I was assured that a focus group for consumers and families is forthcoming. It never happened.
February 25 – I was not invited, but took a chunk out of my workday nonetheless, to attend the small PHF "stakeholder" group in Martinez. Donna was not present, Suzanne was. In the course of discussions I asked what other alternatives were explored for use of the MHSA Capital Funds. Suzanne said that "we" must come up with alternatives if we want them. I could draw no other inference but that other opportunities for these funds were never considered by County Mental Health.
February 26 – At the Commission's monthly meeting our workgroup served Mental Health a one page letter of questions, approved by the Commission, about the proposed Mental Health Recovery Center. This has never been answered.
March 26 – Our workgroup presented another one page letter to Mental Health with additional follow up questions at out regular monthly meeting. It was never answered. Lengthy reports were given by Donna and Sherry. Incredibly, there was no mentioned of the Request for Proposal that was to go out a few days hence.
April 4 – I discover than an RFP was going out to interested program contractors on Monday April 6th. The RFP is dated March 20, six days before our March 26 MHC meeting. This is commonly known as a lie of omission.

2) Discussion and possible action on recommendation to the Board of Supervisors on PHF

Art presented the draft of a letter he proposed sending to the BOS, copied to the CAO, Health Dept., Mental Health Dept., Finance Dept., State OAC, and the State DMH (printed below):
"This Contra Costa County Mental Health Commission recognizes that the process for activation of the Capital Projects portion of the Mental Health Services Act has not been conducted in a forthright fashion by the County Health Department and the Mental Health Department.
"The stakeholder process has been skewed such that concerns and input from consumers and the families have been largely ignored in direct violation of the Mental Health Services Act mandates. Countless requests for information have not been answered. As a consequence the Mental Health Commission has been unable to exercise its oversight duties as required by law. In fact we have been intentionally deceived throughout the proceedings.
"Therefore we request in the strongest possible terms that the

Contra Costa County Board of Supervisors:
1. Immediately put a stop to any further progress on the Capital Projects portion of the MHSA.
2. That the Supervisors require the stakeholder process be restarted, and that it properly reflect the input of consumers and families."

A motion was made (**M-Honneger; S-Kahler**) to send the letter to the Board of Supervisors (with copies to those mentioned above). Discussion followed, during which additions to the body of the letter regarding the transportation issue was requested. Another suggestion was made that there be 3 drop-in centers closer to where people live. A question regarding miscommunication with Supv. Bonilla around the issue of the Commission supporting the PHF was mentioned, with the suggestion a letter be sent expressing the Commission's misgivings concerning the PHF. Teresa gave background information regarding the PHF proposal. A letter from the Commission that was presented to the BOS on April 22, 2008 was distributed. Also distributed was a detailed history of the PHF proposal as it was presented to and then followed by the Commission, along with comments from Veronica Vale. Teresa expressed her feelings regarding a lack of communication and her frustration at not being notified of meetings, specifically the BOS Finance Committee meeting. She distributed an e-mail exchange in which she expressed her concerns to Supv. Gioia.

Peter: We have direct testimony, we have hearsay. My concern is that the Commission has asked for information and the information is not forthcoming. That needs to be addressed. Until we get an opportunity to see the details on the PHF, it's hard to know what to recommend to the BOS.
Donna: I'm a little confused because Suzanne and I have been meeting with members of the MHC and NAMI since September, so to say there have been no meetings or information is erroneous. If that information isn't getting to others, that needs to be looked at. We were remiss in not having consumers and have tried to remedy that. I planned to present the follow-up reports in my report today.
Peter: Information I have received was that there wasn't enough information passed along to any of those participating. In fairness to Donna, if you want to address those issues, please go ahead and do so.
[Skip to Agenda Item 8b below.]

Following Donna's comments, Peter suggested amending the motion to having him develop a letter to go to the BOS requesting a decision to hold off any further action until the stakeholder process is basically restarted.

Peter: draft a letter to the BOS (and cc

He further suggested that a second letter be drafted expressing their concerns. The amendment was accepted. Bielle: I'm going to abstain because I haven't been a part of the experience. But I did want to understand a little about the capital projects…is there any financial ramifications to stopping that process? Donna: My understanding is the property has been leased through June. If the lease lapses, the county could lose the property. Peter called for the vote on the amended motion. The motion carried on a vote of 7-0-1 (Bielle abstained).	*to CAO, Health Dept., Mental Health Dept., Finance Dept., State OAC, and the State DMH)*
7. CONSERVATOR'S OFFICE UPDATE - Eric Cho a. Update on Conservatorship program staffing and morale issued since Ednah Friedman's report to the MHC. Eric Cho Program Manager, Conservatorship/Public Guardian, stated he took over from Ednah Friedman one year ago. The office is now fully staffed and they have moved to 1111 Ward Street. He stated morale has improved since he's been here. b. Policy and procedures on performance (How do you quantify and qualify performance of program and individual conservators). He reported they have regular performance evaluations on an annual basis. They are requiring all deputies be certified with the state. c. Anything new and innovative. They've started having the departments cross training so all are familiar with procedures. They are also working on elder abuse and probate issues. Another thing they're doing is exploring upgrading the computer system. He reported they are also currently working with the auditor's office for suggestions and input on improving efficiency. In making this progress, Mr. Cho said he wants to promote a "Can Do" attitude and hopes the BOS can continue to support the program so they can supply services. Teresa complimented Mr. Cho and his staff despite disagreements she has had. She praised his new location and said she would also would like to see the BOS support their program. Eric: What I try to instill in this group when addressing morale is that nobody is in this alone; we all work with other agencies. I don't see disagreement as a negative thing, as it presents other options. Peter: How do you qualify and quantify the performance of your department? Do you have a set matrix you look at? Eric: Basically, our program is accountable to the court, so if there is any kind of feedback that tells us we are to improve our service delivery, it often comes from the court, so that's the best feedback we can get. My philosophy is I always have an open door policy. Peter: I was looking at more specific information. Mr. Cho distributed a written report, portions of which were read at the	

meeting.

- The Conservatorship/Public Guardian is comprised of three units: 1) LPS Conservatorship; 2) Public Guardian (probate); and 3) Money Management for conservatees, dependent adults, and consumers in the Adult Mental Health system. The office is currently staffed by a Program Manager, a Program Supervisor, a Properties Trust Officer, two accounting staff, two clerical staff, two Mental Health Community Support Workers, and ten Deputy Conservators.
- Two Deputy Conservators are primarily responsible for LPS Intake (temporary conservatorship). They conduct investigations to determine if a consumer is gravely disabled due to a mental disorder and needs to be involuntarily confined in a locked psychiatric facility for treatment. Intake deputies also file petitions for temporary conservatorship with the court.
- Four LPS Deputy Conservators provide services to a caseload of permanent LPS conservatees who may be conserved for up to one year.
- The four Probate Deputy Conservators serve individuals who have been referred by either Adult Protective Services or a hospital and have a primary diagnosis in the organic spectrum, i.e. Traumatic Brain Injury, Dementia, Alzheimer's disease, etc.
- The financial and operational unit is comprised of two Accounting staff who assist the Properties Trust Officer to meet the requirements of the Money Management program. This program provides and manages trust, estate, court accountings, and other fiduciary documentation as required by the court on behalf of conservatees.
- Finally, two clerical staff are responsible for all clerical/ reception duties, and two Mental Health Community Support Workers assist in tracking eligibility for benefits and also transport conservatees to hearings and treatment appointments.

Donna: There are performance indicators, not just quantity. We have staff that look at this. We can look at markers.
Peter: Family members are important as well.
A comment was made that another indicator is the many hospitals, nursing homes, and assisted living homes who call for probate conservatorship.

By means of Public Comment, Janet Wilson distributed copies of the CA State Welfare & Institutions Code Sections 5357, which described rights a patient could lose under conservatorship, including:
1. License to operate a motor vehicle
2. Right to enter into contracts

3. Right to vote 4. Right to refuse or consent to treatment related specifically to the conservatee's being gravely disabled 5. Right to refuse or consent to routine medical treatment 6. Right to possess a firearm. Janet continued on to state that the many out-of-county placements are of great concern to patients' rights. Mental Health Consumer Concerns does not have a formalized position on conservatorship. But for those who are gravely disabled, she stated she would hope for more checks and balances. d. Discussion and possible action on recommendation to the BOS of Supervisors on Conservatorship Program status. No further action was recommended. Further discussion is needed to understand the performance of the department. Peter thanked Mr. Cho for his report.	
8. REPORT: MENTAL HEALTH DIRECTOR – Donna Wigand, LCSW a. Budget Update. Due to time constraints, no report was given. b. Present follow-up reports. Donna distributed information that had been provided to the BOS Finance Committee on April 1. Commissioners received a copy in their packets. This was not received electronically. Additional copies are available at the Commission office. The PHF is one of three programs . From the report (Page 2, last paragraph): "On April 22, 2008, the BOS approved moving forward with the financial feasibility stage of the project. This approval. Included (1) obtaining an option to buy the 20 Allen Street property, (2) Performing a building evaluation of the site, (3) Issuing a Request for a Community Based Organization to run the program, and (4) Closing or downsizing the inpatient unit at CCRMC." She then referred to the last page, which contained preliminary revenues/cost estimates. She stated the capital dollars from MHSA can be used for new programs which are not locked or the side of the center used for 5150's. They can only be used to build drop-in voluntary or residential. She added that this has gone to the Finance Committee and the only motion has been to look at the feasibility, Art: I agree that after seeing the figures, we may agree this is a good thing. But the feeling of most of the people is that we can serve more people by putting facilities at the extremities of the county instead of at CCRMC. Steven: A drop-in center at this location would rule out access to west county. Donna: In the original planning, there was talk about more 24/7 urgent care and more beds. Regarding the RFP, I was told to do an RFP just to see if there was anybody interested.	

Suzanne: The crisis stabilization part must be in close proximity to a hospital and have 24 hour emergency care. My apologies for not getting to moving forward in meeting with consumers sooner. Colette: Access is a problem for central county too. My concern is that the level of care is not going to be as good at the PHF. I fear we'll lose the 10 beds because of the private organization running the PHF losing money. Teresa: I wanted to comment on the CSS forms…I read the documents, then came across a report from Nancy Frank about crisis residential, but we do not have any in west county. Maybe if we had a few more wellness and recovery or dual diagnosis centers we wouldn't need a PHF. I support Art's motion, and I would also like to see consumer's present. Brenda: Regardless of what happened, it's clear there have been some breakdowns in communication, but also there was probably no one who was available to organize that effort as the consumer-run organization in this county did not have the capacity to do that. Is there a way to re-start the communication in a way that will lead to a resolution rather than who was overlooked and not overlooked, so the voices are now heard? If this is not already a done deal, let them now be heard.	
9. CHAIRPERSON'S REPORT - Peter Mantas a. Update on last MHC comments b. Report on Human Resources meeting and hiring (Review list of open positions and status) c. Reaching out to the Oversight & Accountability Commission (OAC) and other County Boards/Commissions for best practices d. Understand everything about the MHSA – Educate yourselves Due to lack of time, there was no Chairperson's report.	
10. FUTURE AGENDA ITEMS Any Commissioner or member of the public may suggest items to be placed on future agendas. a. Suggestions for May Agenda [CONSENT] 1. Public transportation issue for Consumers 2. Consider formulating a position on the Mental Health Coalition key issues • Disconnect of Services for consumers in all age groups. • No continuum of care. • Treatment Silos creating barriers. • Proposed budget cuts may impact Patient's Rights services. • Concerns expressed about the lack of action, from stakeholders, to unite and drive strategies for improved, integrated services. • Discussed communication barriers and breakdown of partnerships.	

3. Case study b. List of Future Agenda Items: 1. Presentation from The Clubhouse 2. Medicare issue – added revenue stream 3. Presentation from the Behavioral Health Court 4. Follow-up report on the Behavioral Health Court's grant application. c. List of Issues for April 30th MHC Planning Meeting (Retreat): 1. Children's Workgroup 2. TAY & Adults' Workgroup 3. Older Adults' Workgroup 4. Consider moving the monthly MHC meeting to the 1st or 2nd Thursday 5. Creative ways of utilizing Mental Health Services Act Funds 6. Discuss MHC Fact Book Review Meetings with Appointing Supervisor	
11. PUBLIC COMMENT. [Remaining] There was no Public Comment.	
12. ADJOURN MEETING The meeting adjourned at 6:30. The next regularly-scheduled meeting of the Mental Health Commission will take place May 28, 2009.	

Respectfully submitted,
Karen Shuler, Executive Assistant
Contra Costa County Mental Health Commission

SPECIAL MEETING OF THE
CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION
DRAFT COMMUNITY SERVICES & SUPPORTS 08/09 PLAN
PUBLIC HEARING ♦ APRIL 29, 2009
MINUTES

1. **CALL TO ORDER / INTRODUCTIONS**
Commission Chairperson Peter Mantas called the meeting to order at 6:18 p.m.

Commissioners Present:	**Commissioners Absent:**
Clare Beckner, District IV	Bielle Moore

Art Honegger, District V — Supv. Mary Piepho
Dave Kahler, District IV
Peter Mantas, District III
Colette O'Keeffe, District IV
Teresa Pasquini, District I
Annis Pereyra, District II

Other Attendees:
Sherry Bradley, Mental Health Services Act Program Manager
Karyn Cornell, Supv. Piepho's office
Brenda Crawford, Mental Health Consumer Concerns
Cyndi Downing, Mental Health Administration
Al Farmer, NAMI-CC
Ronald Johnson, Family Member
Victor Montoya, Adult Mental Health Program Chief
Mariana Moore, Human Services Alliance
Elvita Sarlis, Mental Health Administration
Dorothy Sansoe, Senior Deputy CAO
Karen Shuler, Executive Assistant to the Mental Health Commission
Suzanne Tavano, Deputy Mental Health Director
Veronica Vale, NAMI-CC, Family Advocate, Consumer
Donna Wigand, Mental Health Director

2. **OPENING COMMENTS BY MENTAL HEALTH COMMISSION CHAIR**
Peter thanked the attendees for coming and said everyone was welcome to give their comments. Attendees were introduced.

3. **PUBLIC COMMENT: NON-AGENDA ITEMS**
There was no Public Comment on non-Agenda items.

4. **DRAFT COMMUNITY SERVICES & SUPPORTS 08/09 PLAN PRESENTATION BY MENTAL HEALTH DIRECTOR DONNA WIGAND, AND MENTAL HEALTH SERVICES ACT PROGRAM MANAGER SHERRY BRADLEY**
Peter introduced MHSA Program Manager Sherry Bradley and Mental Health Director Donna Wigand. Donna welcomed everyone and thanked them for attending. She stated the goal is to get their input and feedback into this Plan. She added they are here to listen to your comments tonight.
Sherry presented a powerpoint of the original Community Services and Supports 3-Year Program and Expenditure Plan. (Copies of powerpoint were distributed.)

Donna: Workplans 1, 2, and 3 were contracted out to our community partners. Each was a collaboration to run the Children, TAY and Adult program. The Older Adult was the one we kept in house because it is integrated into the clinics and our staff will be co-located at the heath care centers. These numbers are for a year ago.
Art: I didn't notice any housing for the seniors.

Vic: Because it's not a full service partnership, housing is not required, but we will take advantage of opportunities as presented such as Villa Vas Consuelas. Also, we've been developing board and cares, including one that is out of county. It's a work in progress.
Sherry: There's a separate pot of MHSA money for CAL FHA to administer.
Vic: When state program 2034 shut down, we used one time money because we had established a relationship with our county housing and attached onto their Notice of Funding Availability to make Villa Vas Consuelas available. We're working with West County on the Lillie Mae Jones project -- 8 multiple use units. Also, Rubicon had the Virginia Apartments that needed to be kept up, and we helped them rehab and save those properties.
Suzanne: We also have community-based teams with the intent of keeping older adults in place so they wouldn't lose whatever housing they had.
Teresa: If you have an older adult consumer living with an elderly relative, your goal would be to still keep them in place? Do you have any examples…I know of people who have older adult consumers living with them and this is not good.
Suzanne: This is new, but there have been some outstanding stories of successes.
Sherry: We have a couple of success stories from Community Servicers and Supports. (Copies of examples of success stories were distributed.)
Sherry next presented an MHSA Community Services and Supports Plan Update for FY 2008-2009. (Copies of powerpoint were distributed.)
Sherry stated Input has been going on since last summer. It's a status quo plan with some expansions.
Art: What are parent partners?
Sherry: In the Children's Mental Health System, we hire parents to be peers or mentors to other parents of children in the mental health system.
Donna: we are also creating additional "Gloria's" – we put one in each region and have them available for the adult system.
Peter asked for a better definition of "wraparound".
Donna: Using wrap facilitators is an evidence-based practice for children and their families. It has been going on across the country for about 10 years. It is a mobile service wrapping services around the family where they are. It pushes the staff out to where the families are. Parent partners, licensed clinicians determine what are the services and supports that family needs to get to a better level of functioning. Wrap facilitators are folks who work with the wrap team -- it's a multidisciplinary team – the facilitator coordinates the team.
Suzanne: The wrap facilitator goes in and has the family at the core and identifies who their support people are in their lives and that team is built around the family. The family identifies strengths and needs and then the wrap team sees how they can help.

Annis: Adult wrap facilitators are offended by the use of wraparound "wrap" facilitators. It can be confusing.
Donna: The service itself is called wraparound.
Annis: But shouldn't be shortened to "wrap" facilitator.

Peter asked about the wellness program.
Suzanne: About 2 years ago we started working on this. There are 2 nurses assigned to each clinic. We have a nurse practitioner who will be brought in to coordinate physical health and mental health. They go to the Wellness Centers and clinics. We want to incorporate people to help with smoking, diet, and physical health's relationship t mental health.
Colette: What about bringing this service to people's homes?
Suzanne: We hope to, but are doing what we can with what we have and want to expand to children and adolescents as well.
Colette: Does the plan show the currently going out, coming in?
Sherry: Current FSP's. The tool we use that is required by the state does not allow for flexibility.
Mariana: Is there an assumption they will stay enrolled?
Sherry: Disenrollment is not shown – it reflects a level of recovery.
Donna: One of the premises is that you don't kick people out of treatment, but people "backslide". The goal is you don't let people drop off the radar.
Colette: Are there any quantitative analysis of achievement?
Suzanne: There are reporting requirements for the state, so all the providers and FSP's are sending them to the state, but the state is not returning anything to us, so at the local level we will have to analyze the data.
Sherry: The state's outcome quality improvement has been disbanded.
Teresa: So we have no county-based performance outcomes that were built in to see how we're doing?
Donna: More than just reports…when we saw early on that the children's and TAY programs had trouble getting people in, we met with the providers and started looking into it. We worked with the provider and said we wanted the numbers to go up as well as the quality. The TAY is struggling because some of the 16-25 year olds refuses to enroll due to stigma. The drop in and outs happens most with TAY's.
Peter asked that comments on the plan be held off until Public Comment period and questions be asked for explanation. Peter said there was a need for qualitative as well as quantitative information.
Vic: Regarding quantitative issues on adults…the number of individuals we are currently servicing are our targets. These are existing organizations that have been working in West County for several years and we know who is in crisis, at the hospital, in locked facilities, etc. The numbers are what they need to be. Also, we've developed a relationship with the public health entity -- so we purchased shelter beds. If we have folks on the street, let's get them off the street. Qualitatively, we will and can go back and do a review of all the FSP's and review the adults and TAY's -- looking at the number of people housed, hospitalizations, living situations, number of incarcerations

before and after being enrolled -- those numbers are going to look very good. We can look at benefits before and after enrollment, those who work or students, etc. We'll come back and do that for the Commission.

Suzanne: We've been tracking numbers on outreach and engagement. I think we were overlooking the measures we were sending on to the state because we were waiting for information back from the state, but we need to look at them instead of waiting. It's time for us to act by looking at our own data and bring it back here and work with the Commission on what data we have been working on. We feel the personal stories are important, and quantitative, but we have to build in the qualitative.
Colette: I would hope that physical health would be related to mental health.
Vic: As part of the county structure we have a formal health disparities project that reports directly to Dr. Walker. We went back to and looked at consumers and their health disparities. About the TAY…the TAY collaborative was new to West County. The challenges were that these were the proposals that were presented to us -- they had to establish a site, hire program managers, etc. By the time we let out the RFP, we were in less than a 2-year operation -- so it has been challenging, along with developing relationships within that community who were strong in the mental health system. We have looked at some of their strengths and the referral sources. It's a challenge to expand services across the 3 regions. One of the referral programs was GRIP. The positive was that we used one time money for a 12-bed house. We also got Bissell Cottages for TAY's. We have tried to build relationships. Challenges going forward: they are small programs. Philosophical challenge in thinking "we are only serving 60 TAY's". We need to give them credit for the good work they are doing.
Peter: Going forward…part of the plan should include (pursuant to the Welfare & Institutions Code) reports on achievements on performance outcomes established. Along with talking about the programs, we need to have the qualitative and quantitative reports. If you see how you're performing, we can be much stronger.

5. **PUBLIC COMMENT: DRAFT CSS 08/09 PLAN**

Veronica Vale: The challenge will be to ensure that IMPLEMENTATION ACHIEVES THE STATED GOALS OF THE LEGISLATION TO PROMOTE RECOVERY AND REDUCE THE NEGATIVE CONSEQUENCES OF UNTREATED MENTAL ILLNESS, including suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from their homes. These could be outcome measures. The lack of clear policy and guidance on evidence-based practices leaves much uncertainty about potential effectiveness of the strategies adopted by the county. Program success also, will depend on the counties' ability to recruit, hire, train, and retain qualified staff, consumers, and family members who reflect the cultural and linguistic diversity of the consumers and are committed to integrating recovery principles into all aspects of program implementation. Will WET, Workforce Education and Training monies be used do fulfill this promise? Will CBO staff be trained too? We have a great responsibility to make choices that are based on hope, empowerment, self-determination and meaningful roles in society which are the principles most beneficial to

the consumers and the community. The family positions are vague. Which ones are parent partners, which ones are families with children and do these mean children

under 18? Which ones will be in the adult clinics and which ones will be in the children's clinics? Page 9 and 10 do not delineate new positions even though the narrative talks about them? The Office of Consumer Empowerment is now getting more staff again after three years. The county originally paid for this staff. Is this not a supplantation, which is not allowed under the MHSA? Even though it was said there was a hiring freeze. What has changed to make it possible to hire now? Why are not the out-of-county people leaving the Long-term MH hospitals not getting services through FSP's programs? Does the expansion of the far east County include Antioch?
Sherry: It hasn't happened yet.
Donna: There has been discussion with the providers but it hasn't happened yet.
Veronica: The Office of Consumer Empowerment was funded by the county -- how can you use MHSA for this? It was an already-existing position.
Donna: They were contractors and have been gone for 4 years. We are now able to create positions.
Veronica: It looks like you're funding positions that are already there. What about people leaving long term beds out of county?
Teresa read a letter addressed to Peter Mantas, Chair of the Commission, submitted by Mashariki Kurudisha, who was unable to be there. "I am a member of a family which has used the services of the mental health system of Contra Costa County. I have been serving as a member of the Family Involvement Steering Committee for MHSA. I would like this public hearing to include my views of the Community Services and Support (CSS) Program. First, however, I would like to again convey to the MHC the March 26, 2009 letter with attachment from the Family Involvement Steering Committee for MHSA regarding the CSS Program. Please include this letter, the MOC and the March 26 FSC letter with attachments in the MHC consideration and review of the CSS Program. The Family Involvement Steering Committee for MHSA has worked hard to have the voice of families included in the MHSA process in Contra Costa. We work not just for our own families but for all families facing mental illness. Personally, I am disappointed that we have yet to answer the question of what equals support for the mentally ill. This is a question that is not decades from being answered but centuries. I know that today some ones family member left Contra Costa County jail or juvenile detention center not functional and without needed mental health support. The same thing will happen tomorrow. I know that I can go to the streets of this County regardless of the city and find homeless mentally ill. At the same time, CSS waits for the next ill, unsupported soul to request service as a full service partner. The CSS program has not met its youth numbers and the proposed solution is to reduce the number that the program should include. At the same time, 19% of the population today in the County jail is mentally ill and up to 100% of the youth in juvenile detention and their families are in need of mental health support. There is a basic failure here. I see the fights over budget reductions in the County. At the same time, I look at the Council of State Government Justice Center recommendations and I know that reducing the return of the mentally ill to jails and detention centers where most of them receive only enough mental health support to control them is a state, national and international goal. Contra Costa could innovate to insure that the moment a

mentally ill client leaves jail, detention, the emergency room, the office of a local non-profit, the door ways of commercial areas, under the freeway, or a family home in need of immediate attention them is a means to have an outreach worker there to guide them into the system of care as a chosen options to beatings and death. That guidance could include needed paperwork and other supports up to and including those services provided by an ACT Team. Such a response would need to include mobility and flexibility of time and deliver. CSS says it has this but the results speak for themselves. Our County example of a student preparing for an improved life with mental illness was an example of the beating and death experienced in this County by the mentally ill. The CSS program has been envisioned to include supportive housing and supportive services. What we have today is a small step towards what is needed. I believe that our measure of delivery needs to be quantitative and qualitative. We have a program that can only tell us the limited numbers of people served. We cannot tell whether the services were beneficial to the population served. This leaves us without a means to improve serves. The Mental Health Commission must determine what is working as a service and what needs improvement. Best practices for the County need to be defined and then documented. A database of positive treatments, drugs and supports which helped someone achieve some positive outcome would be program dollars well spend in my opinion on mental health. My hope is that by the next program review, we can know that we has at least begun to create such a brain trust of recovery for the mentally ill of Contra Costa."
[Ms. Kurudisha asked to have other materials placed in the record. However, while the above letter was read into the record at the meeting, although other materials were referenced, no copies were available at the meeting nor were they read.]

Peter: What was her basic comment?
Teresa: She wants the Family Steering Committee letters included.
Donna: She suggested an innovative program, similar to assertive community treatment.
Colette: I would want checks and balances to protect consumer's rights
Teresa: We as a Commission need to consider consumer's opinions.
Colette: They should not be considered as an afterthought…
Peter: The measure of delivery needs to be quantitative and qualitative.
Veronica: Evidence-based practices.
Colette: What's the evidence for evidence-based practices?
Mariana: In terms of quantitative and qualitative, one of the things I've heard is making a lot of assumptions that may or may not be based by facts. I would like to caution against assumptions. We should have a rigorous and fair process to look at the facts. I hope to build into the process being thoughtful and include the providers and consumers in the conversation.
Brenda: Regarding the wellness part of the plan -- expand it beyond its present scope -- look at physical and mental wellness and vocational services, making people feel good about themselves. Look to support SPIRIT but other models as well to provide job training.

Al Farmer: Can the capacity of the programs be adjusted as the program approaches capacity with regard to housing, etc.? With regard to MHSA FSC, will its being rolled into CPAW limit our voice?
Ron Johnson: Looking at the number of children in the FSP and the per capita cost, it seems outrageous. What is the source of the children in the program? If we have 50,000 mentally ill in this county, this isn't a sufficient amount of money -- there will be breakdowns in the future.
Peter: On this particular issue, can you address the per capita cost?
Sherry: All counties measure the cost differently. We've been looking to the state to provide a guideline. The cost of FSP's per capita tends to be very high because all services go to these. The state has given us no standards.
Ron: Regarding the graph…what made this thing kick up? There's a much larger population receiving no services. The action you took to make it kick up seems to be a source of real effectiveness.
Donna: I've been troubled because the MHSA has built a two-tiered system. Some get a lot, some get nothing.
Art: Is this written into the proposition?
Donna: Yes. Who gets in and who's allowed to get in.
Teresa: DMH has expanded the definition for next year.
Donna: Requests came to loosen up and allow us to serve more of the populations. I haven't been able to do that for the last 4 years, but will be able to try to do it in the future.
Suzanne: I think in going back to Vic, getting new programs up and going takes time, and at some point we do pause and see if we overestimated in one area and underestimated in another and need to modify.
Peter: Going back to original question, $18,000 for FSP -- what are the top 3 costs and what percentage?
Vic: Staff, staff, staff.
Suzanne: Costs get lower as enrollment goes up. Costs of services to children tend to be higher than for adults.
Peter: A % of capacity would give us a better idea of how much per individual.
Sherry: It's not close for children.
Vic: The other complexity is the state tried to put MHSA side-side with our county Medi-Cal clinics so we have to meet all the trappings of Medi-Cal so Medi-Cal costs are very expensive. Also critical is the caseload ratio. A year and a half isn't enough time.
Ron: The TAY program people will not discuss the issue until his healthy families coverage drops off. The 23 year old thinks he has both. His current providers are not covered by Medi-Cal -- people who have his trust will end.
Vic: We might be able to fix that one.
Ron: It's a tragedy that the good services might end.
Peter: Break in continuum of care -- how can we phrase that?
Vic: We need the details in order to tell. It's too nuanced to develop a program

around that.

Suzanne: There's the level of changing health benefits. They turn 18 and they either lose their benefits or they change or they can say "No"
Peter: Can it be part of the CSS plan?
Donna: It's a larger issue. It would take a change in regulation.

6. **CLOSE PUBLIC COMMENT ON THE DRAFT CSS 08/09 PLAN**
Peter called for a motion to close the Public Comment portion.
M-O'Keeffe; S-Beckner. Unanimous.

7. **MHC COMMENT ON THE DRAFT CSS 08/09 PLAN**
Teresa: Going back to the discussion of oversight of providers and being mindful of Mariana's comments about assumptions…all we want are good services. Those missed opportunities can be life-altering events. We need better communication for the sake of people's lives and family member's lives. There's things that are troubling – comments that Steve hadn't been contacted by the county about the plan. The assumption by the public taxpayer is that these conversations are ongoing. It's a struggle in that breakdown of communication and the impact on the consumer. At the MHSA Steering Committee there was conversation about renewing communication. It's very troubling that this plan is just being submitted near the last day of April. That's $16,000 million that's sitting up at the state and not coming down here. A lot of other counties were able to get their plans in. The TAY thing -- there's family members here who get that. We do live stories that would benefit your staff and the providers. It's disappointing that we don't have families in the discussion with the providers. It's troubling there's only 3 family members at the table and not more embracing of this service.
Teresa gave a copy of a Supportive Housing Plan to Sherry.
Colette: Is work being done for the TAY program to decrease the feeling of stigma, so they are more in line with their assessment of their needs? No consumers were invited either to Fred Finch. Regarding outcome analysis -- the consumers should be in there deciding what those goals are to evaluate ourselves.
Clare: In the proposal to expand housing…what is your definition of housing and what are regional housing specialists?
Donna: We should provide a definition in the plan.
Art: What happened to people when beds were closed?
Donna: We bought new beds that were added to the system.
Annis: Back to a comment from Teresa…an older adults living at home when there are no housing services provided because an older adult is not an FSP. The example that is given matches my experience. What are you going to do with someone who is intrusive and delusional and needs to be taken out of the home…what are you going to do for housing?
Suzanne: The FSP's have inherent in them provision for housing…but we find a place for them not under FSP. But part of the planning process should be older adult FSP's.
Dave: Is the Clubhouse supported in the CSS plan?

Sherry: Not in CSS -- in the PEI.

8. **MHC ACTION – DEVELOP LIST OF SUBSTANTIVE COMMENTS**

Items addressed on the flip charts:

- Wellness
  - Taking services to consumer's homes
    - Stop smoking
    - Nutrition
    - Safety in the home (mold, etc.)
- Vocational services
  - Recruit, hire, train and retrain, integrating recovery principles
  - Self-determination
- Evidence-based practices
  - More requirements, outcomes, contracts, ongoing data
  - Quantitative and qualitative data
- Expansion of services to far east county
- Develop a system to avoid break in continuum of care
- Include the Family Steering Committee Memorandums of Concern and the responses in the Plan

Peter: I feel they are all substantive and all should be addressed. I think we should approve all of them as substantive to be addressed in the plan update.

A motion was made to request that all Public Comment received to considered substantive and be addressed in the Plan update.

M-Honegger; S-Pereyra

Brief discussion followed.

Suzanne: A great majority of the comments will have to do with the plan update but some are future issues.

Carried unanimously.

9. **MHC ACTION – MOTION ON RECOMMENDATIONS TO THE COUNTY MENTAL HEALTH ADMINISTRATION AND TO THE BOARD OF SUPERVISORS**

Peter: The plan is behind and we need to move it forward. I'd like to entertain a motion to conditionally approve the plan updates assuming the following:

1) There be balanced representation on CPAW (county staff, mental health staff are at a minimum on CPAW and a significant portion is made up of family and consumer representatives to get more people involved in the decision-making process.

2) There is heavy involvement of family and consumer members not only in discussion but also decision making (CPAW)

3) Mental Health Administration will work with all stakeholders, especially the Mental Health Commission to develop quantitative and qualitative analysis of MHSA program performance by August 31, 2009.

4) All noted substantive comments get addressed in the plan update with Mental Health Commission involvement – for discussion and review before it's

submitted.

Colette: I request that the word consumer would come first at least 50% of the time.
M-O'Keeffe; S-Honegger.
Discussion followed.
Suzanne: Amend the way it's structured in MHSA…make recommendations to Mental Health Director?
Peter: Yes. We put these steps in place so we can sit down and talk. We want to work with everybody to make sure we're discussing these things with everybody
Mariana: Will another meeting of the Mental Health Commission be required?
Teresa: It needs to be discussed at CPAW but I don't want to jeopardize these funds.
Sherry: Point of order…according to the stat sheet…when we make changes that are substantive we have to recirculate the plan so the public knows the changes have been made. I don't think it requires another public hearing.
Donna: In an ideal world it would be nice if everybody was on the same page. I don't have that expectation that everybody with a special interest will see things the same way. I don't expect everyone to agree at the end of the day.
Peter: We are all on the same page in terms of communication. How do we get involved?
Sherry: There's documentation of all the comments -- name, date, how we responded, what's the change, circulate.
Suzanne: What triggers the whole process is the use of the word "substantive."
Sherry: Most counties consider all comments substantive. Whether or not it leads to a change is contingent on the guidelines. How is "heavy involvement" defined?
Peter: We can figure this out. 51%? The Steering Committee was 90% Mental Health Administration. That needs to change.
Motion carried unanimously.

10. **CLOSE PUBLIC HEARING**

Peter thanked those who attended. A motion was made to close the Public Hearing.
M-Pasquini; S-Pereyra.
Motion carried unanimously.

Respectfully submitted,
Karen Shuler, Executive Assistant
Contra Costa County Mental Health Commission

Mental Health Commission Planning Meeting
April 30, 2009
MINUTES

Purpose of Planning:

- New members will become more oriented to their role and the role of the Commission
- Commission members will agree to work as an effective team on behalf of the mental health community and the Board of Supervisors
- Refine the Commission's focus items for the rest of the next year

1. Welcome – Peter Mantas, Chair

Chairperson Peter Mantas called the meeting to order at 3:55 p.m.

Commissioners Present:	Commissioners Absent:
Clare Beckner, District IV	Supv. Mary Piepho
Art Honegger, District V	
Dave Kahler, District IV	
Peter Mantas, District III	
Bielle Moore, District III [Left the meeting at approximately 5:30 p.m.]	
Colette O'Keeffe, MD, District IV	
Teresa Pasquini, District I	
Annis Pereyra, District II	

Non-Commissioner Attendees:
Brenda Crawford, MHCC
Jeannie DeTomasi, Mental Health Administration
Anne Heavey, Family Steering Committee [Arrived at approximately 6:15 p.m.]
Mariana Moore, Human Services Alliances
Karen Shuler, MHC Executive Assistant
Suzanne Tavano, MH Administration [Arrived at approximately 6:15 p.m.]

Tomi Van de Brooke, Supv. Piepho's Office [Left the meeting at approximately 5:30 p.m.]
Donna Wigand, Mental Health Director [Left the meeting at approximately 5:30 p.m.]

2. **Agenda review; establish ground rules for the planning process**
No discussion.

3. **Introductions and getting acquainted**
Peter said that before they got to reviewing their ideas of the Plan they had already developed last year, he wanted everyone to introduce themselves and give each other an opportunity to ask some questions so everyone can learn a little more about each other and understand where everyone's coming from. Each Commissioner and others present told about their backgrounds and how they got involved with mental health issues.

4. **Discussion and agreement on how the Commission will organize itself**
   - Review the role of the Commission (W&I Code)

   Peter stated there was no time for discussion of the W&I Code today. He encouraged the Commissioners to take the time to go through it to help understand what they're here for from a legal perspective.
   Peter then posed questions as to what they are here for, what is their purpose in being on the Mental Health Commission, what are they trying to do? Who is their focus?
   Colette: One thing is to explore issues that are coming up, decide what the consensus of opinion is and help educate the Supervisors.
   Peter added that the focus is the consumer of mental health services and the Commissioners need to talk about this to get on the same page. He said there are consumers who are capable of communicating how they feel about the services they are getting and what their needs are, and there are other consumers who flat out don't know what's best for them. He added they have clinicians and their family, and the glue that ties this all together many times is the family member. What medication is the consumer on, has been on? The family keeps lists to present the lists to other doctors when a handoff occurs. There are no records to tell what medications our loved one, the consumer, has been on. Imagine not having a family member and not having the ability to make that list. How many times does a consumer decompensate because the doctor has to start from scratch on medication again?
   Colette asked to add another support system – the consumer advocacy system. She said they are extremely helpful and can have things in addition to medication, such as the community center, and access to the community center is really important. That will also tie a lot of other issues in, including healthcare. Consumers helping each other.
   Art agreed with Colette and added that the Peer to Peer program should be NAMI's premier program.
   Clare spoke about the Clubhouse being a place for people who have a diagnosis of mental illness. She said it's like the Peer to Peer; it's being with a group of people that can support you.
   Colette added that the Community Wellness Centers are also there for everybody and don't charge.
   Brenda said she sees one of the purposes of the Commission as being a link to all the various communities that are out there. She added helping people develop the kinds of partnerships where effective services can be delivered is important. Brenda went on to

say she intends to go to the Clubhouse director and see how they can work together. Brenda also mentioned she had noticed the vacancies on the Commission and feels MHCC should help recruit. The #1 priority, she said, was to remove attitudinal barriers. Peter remarked that it wasn't family vs. consumers, but that everyone needed to support the consumers to live a full life, and understand that no matter what seat they are on the Commission, Commissioners all share a common purpose. Peter also mentioned the need to bring churches in to help.

Bielle agreed that everyone needs to work together, and mentioned John Gragnani's concern regarding children. She said she would like to see something for the seniors as well – perhaps a big meeting where everyone could interface. She mentioned the Commission also needs to do outreach to the providers.

Brenda addressed the underserved in the county, saying there are cultural issues around mental health. She said part of the Commission's role should be to find out how to access and bring services to the most underserved.

Donna asked to make a statement, saying she didn't want it to be misconstrued because everyone needs to move forward. She said she thinks every individual on the Commission has heartbreaking and very good reasons to be here. She then stated that this Commission, in its current configuration, doesn't represent the consumers that she serves. She explained that there's no one of color on the Commission; other than 1 or 2 people, there's not a wide variety of socio-economic status; and most of the Commissioners are directly affiliated with NAMI. She stated she loves NAMI, but feels the Commission has become a subset and that there isn't a diverse voice on the Commission. She referred to the Public Hearing the night before and mentioned that Colette is being a very strong voice. Donna mentioned the 2 upcoming Board appointments to the Commission are both Caucasian folks who are affiliated with NAMI. She said she doesn't see that dynamic changing, and mentioned that while some may feel that's okay for that to be the voice of the Commission, she feels there needs to be more diversity and more voices.

Responding to a question as to how to change that, Donna replied that Brenda is starting to address the diversity through MHCC. Colette mentioned she had expressed reservations about one of the appointees because of those issues. Donna asked if anyone shared her concern. Dave challenged Donna's comments about NAMI, stating that people gravitate to NAMI. He said those in NAMI come from a variety of backgrounds and have divergent opinions. He went on to say he would question that people would not choose to join the largest, strongest most active support group for people who have loved ones that are mentally ill. Donna replied that she was just talking about getting some consumers of color, and that's what Brenda is doing.

Brenda said you have to be purposeful in your plan. If you want to represent the diversity of this county then we need to do some purposeful planning – not just recruit folks because you have empty seats but recruit folks based on the needs of those communities. The suggestions were made to use CCTV to advertise and to write a memo to the BOS asking them to consider diversity when appointing, so that the appointments reflect the county population. Colette said that because of cuts in SSI, increased transportation costs, etc., finding economic diversity among consumers is difficult. Teresa said she would like to see diversity and hopes the BOS is aware of the W&I Code regarding diversity. She mentioned that transportation is an issue, even with reimbursement. Annis

said some communities that are very close-knit are resistant to outreach. Many prefer to take care of their own. Peter said they couldn't solve everything, but that the goal needs for them to figure out a strategy for getting diversity on the Commission – that they need to develop a plan and start executing it to get that diversity. Art added that the most likely person is somebody who has a background in mental health with a family member. Brenda added that she has some ideas and was volunteering to help. Mariana Moore spoke about her background in working with Latinos. She said the Commission may have to change the way they do business – step outside their comfort zone.

The meeting was paused while the Commissioners enjoyed a potluck dinner.

5. Brainstorming Key Issues (Review and Discuss Each Commissioner's Top Five Issues)

Discussed following the potluck dinner.

6. POTLUCK

7. Brainstorming Key Issues

Following dinner, Anne Heavey made some impassioned comments regarding her son's experiences with Crestwood facilities. She mentioned that the Commission does not have any power, nor does it have any respect. She also spoke against the newspapers taking a stand in favor of Prop 1E.

Peter said that as long as we work together, we'll get something done. He continued by saying that diversity is in all their minds and they need to develop a plan to get people stepping to the plate. He stated individuals such as Donna should take the tone down a bit – that beating the Commission up on issues that happened in the past isn't going to solve anything. He went on to say the Commission needs help in identifying new applicants. Dave stated that reaching out should not be the main issue, the choosing of Commissioners should be based on merit, not just ethnicity, etc. – that the existing Commission should be working on the significant problems.

There was discussion regarding Donna's comments about NAMI. Clare said she was sorry that she was not up to speed about Donna's comments about NAMI. Dave responded that the Mental Health Administration feels threatened by NAMI. Colette said that part of the problem was the way the Commission seats are structured – in the W&I Code and the way the Commission does its Member-at-Large seats. She added it's like having another family member because members-at-large are generally family members and not consumers. It creates a 2 to 1 ratio against consumers.

Peter said that over-generalizing can lead to trouble. He gave NAMI as an example, saying the general perception is that NAMI members are brainwashed. He also gave the Bylaws Workgroup as an example of free thinking and said the Commission has strength and conviction. He cited that even though the four members of the workgroup had taken a position on the proposed amendments; after further discussion with their fellow commissioners they changed their minds during the full commission debate.

Brenda said for her it was not an issue of the Commission having NAMI members, but the issue was diversity – the lack of representation from the underserved communities. Colette added that it was also important to have consumers. Annis stated that the Commissioners need to listen to everybody – whether they're on the Commission or not.

Commissioners need to go out into the community and speak to the people there. Teresa asked who does the advertising for applicants and staff responded the Board of Supervisors and CCTV. Mariana said people need to be brought to the table for their wisdom. The perspective needs to be broadened.
Suzanne voiced an opinion that over the years the Commission used to be socially, culturally, ethnically diverse. She said something has shifted and people have commented on that to her. She said she felt something has changed. It used to be more representative of the county at large. She said she's worked with the Commission for 13 years and there's something different and that might be part of what the Commission is hearing. People were able to be here; they got themselves here so the barriers that are being talked about – you would think those barriers have always been there but people have worked through them and gotten around. It makes one look at the situation and the "whys" and "what do you want to do" to reach out in some other ways.
Peter said he thought we could paralyze ourselves with analysis on what is different, and added that there's nothing different.
Teresa said they shouldn't leave this conversation on a negative. She said this whole thing about NAMI has been out there since the 4 resignations and Bylaws saying not to include NAMI members and there was a clear signal …
Clare mentioned she had been told there were not taking any more NAMI members from her district.
Teresa continued saying there was a definite vibe put out there about NAMI. The NAMI thing and the cultural thing are two different things and shouldn't be mixed up.
Suzanne said she wasn't raising NAMI as an issue at all, but was speaking about cultural diversity.
Teresa replied that the conversation began before she got to the meeting. She asked Suzanne what she meant by "something has changed."
Suzanne gave as an example where meetings are held and the times they're being held. She added she wasn't on the attack at all, but what it meant by talking about the barriers and how to think through the barriers and somehow they were worked through before and she added that she just thinks about the concrete stuff like where, when, how.

There was a discussion regarding times of meetings being different than they used to be. Colette mentioned the change in bus schedules was devastating. Staff responded to questions about times of the meetings.

Peter repeated the need to stop over-generalizing and the need to develop a plan. He added there could be diversionary tactics involved in bringing this stuff up and we need to stop it. He stated "we are good people that are conscientious and we're going to do the best we can. And if people feel that we aren't, then the Board of Supervisors can remove us from the position."

Brenda suggested meeting in Richmond or other areas. She said MHCC would help find a place.

Peter said that the underserved who are stigmatized by mental illness are the ones most challenged by the system. He said the Commission needs to figure out how to bring communities in to help.

Peter asked the Commissioners to list their top 5 issues.
Art:

- At the core is to know where the Supervisors stand with regard to Commission input. He said if it's pure dollars no matter what the harm, there is a problem – Will they act on the Commission's recommendations?
- Historically, it's been hard to get reliable information.
- Closing mental health beds – in fairness why not close other non-mental health hospital beds? The assertion there's a high cost of mental health beds at CCRMC. Other beds are costly, too. Why is mental health being singled out? It has been asserted that when 20 beds were closed, there was an intentional process to bring down the level to a lower number. The 10 beds won't be kept open. It's not fair to do this to the mentally ill. People at Nierika aren't near as well as they have been before, so are some of them who were in the hospital when the beds were closed being sent there? Some police officers don't want to take 5150's anymore because they have a low level of admitting them to take care of them. Art said he'd like a history of how many are admitted between 2000 and 2005. Crestwood closed beds – how close are they to the type of beds they want at the PHF?
- The Commission is supposed to be looking at contracts…Because of limited beds, are the providers in the driver's seat?

Colette:

- The PHF will be contracted to a for-profit agency. Reassurances will be given, but the PHF agency will later say they can't make money so reassurances will go away. The 10 remaining beds at CCRMC will evaporate.
- Ensuring the quality of daily life for consumers
    - Nutrition
    - Safe housing
        - Internal – mold, etc.
        - External – safe to go outside
        - Accessibility to outside resources
            - Working with transportation to get a monthly pass for seniors/disabled

Peter said the Commission needs to see how to augment, how to improve their plan.

Dave:
The Commission is drowning in a tsunami of detail.
He said his interest is only the mental health system. He said it is a failure and essentially does not serve the people it's designed to.
This Commission should focus on telling each Supervisor the mental health system in this county isn't working, and hasn't been working for a very long time. There can and must be systemic change from the top down.

Annis:

- Son is getting services out-of-county because they are not available here.
- There is a need for major things to change.

Mariana spoke about being practical…reaching out to others who have similar concerns. Encouraged the Commission to be thoughtful about who to bring to the table. She added there is understandable frustration that is getting in the way of solving problems.

Brenda encouraged the Commission to focus on children and seniors. She mentioned the committee structure that used to be in place on the Commission and referenced Janet Wilson's letter to the Commission asking that committees be restarted.

There was discussion regarding the reason the standing committees were recessed and then not restarted.

Teresa:
Before listing her key issues, Teresa said she didn't mean to snap at Suzanne earlier.

- Bed count
- Quality of care
- Support of the PHF is not an issue – it shouldn't replace acute care beds – wants a more transparent process
- Commission needs to get beyond communication issues
- Out-of-county placement
- Objects to conversion of Crestwood from MHRC to board and care beds – it's against best practice to live in super board and care
- When we were at the OAC meeting we were re-educated on the term "two-tier" and the wording was changed to "multi-tier." Two-tier/multi-tier system creates haves and have nots.

Teresa went on to say she is concerned about getting all our work done. She said she enjoyed the standing committees but added we just don't have enough people and enough time. She said she can't attend any more meetings and added the Commission needs help from outside sources to get the work done.

Clare:

- Concerned about how diverse our county is and how to unify – each section of the county have totally different demographics. How to pull it together is a concern.
- Very concerned about the removal of acute care beds at CCRMC.
- Feels it's too much for our small group to do. Thinks the Commission needs to settle on 1 or 2 major things and see a result. Closing of the acute care beds seems to be a major concern for all of us.

Anne Heavey said she comes to the Commission meetings because it's the only way she finds out about information. She said she was shocked to hear what was said about NAMI and would like to see NAMI have other branches in this county. She added that transportation is a major issue and no one is listening.

Colette mentioned she had been going to the Operations and Scheduling Committee and have already accomplished getting transfer times increased. A little progress is being made.

At this point Peter asked that the time of this meeting be increased by 15 minutes. The Commissioners reluctantly agreed.

Suzanne said she was speaking from a different perspective than the Commissioners as she worked for County Mental Health. She said she was mystified about the direction things have gone. She said we all want to improve mental health services for the consumers in this county, but speaking personally, she said what makes it very hard is it feels like there's a growing "us-them" dynamic going on and the stronger that us-them dynamic goes, the harder it is for me to feel like there can be an open, interactive sharing communication about how to improve things because if you never know if you're going to be attacked or something you say is might be either misconstrued or taken out of context, it makes it difficult. Suzanne said sides are being drawn and it seems like it's getting harder and harder to come together and resolve things that we all want to resolve. She said she agreed that there were many things that could be done better, and there are a number of people that are being underserved, but it's hard when all that's being said is "It's all falling apart," "It's all horrible," and "It's totally broken" when I know experientially there's that side, but there's also the other side. There are a number of people we are providing services to who feel we are meeting their needs, when it's all negative and no acknowledgment of any part that's going well, it's very hard to have a good, interactive process that leads to productive change between us. I get really dismayed because more that 50% of the people we provide services to our children. The children's experiences might not always line up with how adult experiences are, and she said she wished that was being brought into it also just to round perspectives out. She added that there's an inherent dynamic going on in dealing with consumers and family member perspectives. On the one hand, she said, wellness and recovery moves us to want to think about how adults can be served in less restrictive ways, and that is not always in line with how families see it. She added she comes from a hospital background so she can understand and appreciate that. But there's a dynamic going on here where part of the system is pushing one way and another part of the system is pushing another and how we reconcile those things. Speaking directly to Dave, Suzanne said, "Sometimes it's really hard, you say people shouldn't take it personally, and yet there are a number of us who work 10 and 12 hours a day because we are dedicated to trying to improve things, and when you're made to feel like your work is nothing, it's very hard to then say, 'Okay, so how can we work together on something'."

Peter responded that since we are on that subject of being personal and speaking from the heart, there are ways of taking comments, constructive criticism, these statements can be taken in a positive or negative vein, he believes Mental Health Administration needs to take a good look at what vantage point they're using.
Suzanne: "And how it's stated."
Peter disagreed, stating it wasn't necessarily how it's stated and even the way she was stating it right then. Peter said he hated to go through this in a public meeting, but he felt we started so he needed to make his feelings known. Peter said everybody there, including Suzanne, cares about the services we're providing our family members and other consumers. No doubt. But when you're working in a meeting in a working environment when you're on pins and needles and walking on eggshells thinking about how is it the other person is taking my comments…there are two sides to this story, that it wasn't just the people who are communicating the message, but the receiver of the message and the interpretation and actions that are taken by that message can also be

pretty destructive as well. Peter went on to say that when this Commission requests reports and those requests are consistently dismissed, they're not provided, there is a point in time where the Commission says, "Why is that? Why aren't we getting that information? Is that information we're getting accurate?" Peter added that it wasn't that the Commission has issues with individuals, they have an issue with the problem of communication, and they all need to work on it and, he said, the door is open for us to do that. He added that it was a two-way street, though.
Suzanne responded by saying she thought they were really saying the same thing – that they want to move on and see how they can work together collaboratively.
Peter continued by stating that if something is promised to each other, it should be delivered. He gave as an example that Donna could not come into a meeting saying she was going to give them something and three months later not have given it. Even though there may have been good reasons for not delivering it, unless those reasons are communicated to the Commission, the Commission doesn't know. He stated that Art's Workgroup had put in requests for information and his requests have been dismissed. Peter said that if we all really want to work on this, we all need to work on it together. He added that he didn't think anyone in this room was interested in making anyone look bad, but we need to both deliver on what we promise, and as long as we deliver on what we promise, we're going to be fine.

Peter addressed the issue of the standing committees, and said the work of the standing committees could be done without them being in place. He distributed copies of the Minutes from the Contra Costa County Mental Health Task Force, which he recently attended at the invitation of Cesar Court. He said it is basically a task force for older adults. He suggested the possibility of assigning a Commissioner to the MHTF, so this group could be the Commission's older adult group. He said we could also tap into a similar committee for children's issues.

An e-mail from Janet Wilson was presented. She expressed her thoughts regarding focus items for the Commission that included:

- Need to look at out-of-county placements for both children and adults and the impact it has on their families;
- Recommend having a patient's rights subcommittee on the Commission;
- Having something for the older adults who are underrepresented on the Commission.

Peter:

- His pet project is to develop a Task Force to identify what an ideal mental health system would look like
    - Look at continuity of care for all age groups
    - Target short- mid- long-term issues
    - Get the community involved in the process

8. Refine the Key Issues which the Commission will focus on over the next 7 months

- Workgroups – Capital Projects
    - Quality of Care
    - Beds
    - PHF

- Gaps in the System
- Contract Review
    - Level of service and services not rendered
- Police not willing to send 5150's to the hospital
- Two-tiered/Multi-tiered system creating have/have nots

Peter suggested looking at changing "gaps in services" to "quality of care." Teresa said she felt the W&I Code called for gaps in services to be identified. Teresa said she feels the Commission also needs to get back at looking at the age break-down groups. Peter said the Commission doesn't have the ability to do that and they need to reach out to the community to others to get help in doing that and then ultimately bring that information back to the Commission for recommendations. He asked if there was agreement in that type of approach rather than having our own internal standing committees. John Gragnani's request for the children's committee to be reinstated was brought up, and comments were made that maybe he could help us and a representative from the Commission could go to his group. Teresa mentioned that this is what Sacramento County does. Regarding the Patient's Rights Subcommittee, Teresa said the Commission can't do it now; they can't keep fragmenting. Peter said other groups could do it and the Commission could get feedback.

Suzanne suggested interweaving patients rights into different age groups task forces/ committees. Brenda agreed this was a good idea. She added they just wanted to be sure that the issue of patients rights is always on the table.

Dave gave a statement defending his previous comments, saying when he was making a serious criticism of the system, what he said was system, not people. He said he admired and had affection for Donna, Suzanne and Vic, and added they were in the system as we are and added we fail to state it clearly and loudly, we are all slaves to political correctness which is tyranny with manners and we shouldn't tolerate it. He said the people in Mental Health Administration should be turning to the Supervisors and asking if they realize that essentially it isn't working. Dave added that we don't serve 25% of the mentally ill. He said the decision-makers will say they don't know because the Mental Health Administration isn't telling them, Dr. Walker won't tell them, we won't tell them because of political correctness. He concluded by saying he thought that was wrong.

9. Public Comment
None.

10. Evaluate retreat and adjourn
Due to the lateness in time there was no evaluation.
A motion was made to adjourn. M-Pereyra; S-Honegger. Carried unanimously. The meeting adjourned at 7:34 p.m.

11. Summary of Planning Session comments as summarized by Peter

- Cultural, Racial, ethnic, social group diversity
- Supervisors position on Commission (Independent/Supportive)
    - Meet with our Supervisors
- Information from MHA not provided and or can't be trusted
- Deliver the message "mental health system in this county is not working" Systemic

change is needed… System is in crisis…

- Strategically engage with service providers and all stakeholders
- Standing Committees or other
    - Focus of children and older adults (reconvene standing committees or engage with existing committees addressing this need.)
    - Patients rights (possibly have each committee representing the each age category focus on this independently)
- Quality of care
    - Contract review
    - Are the Contract providers making decisions on level of service and what service
    - Police – not willing to take 5150s to the hospital
    - Two-Tier vs multi-tier System to be politically correct (haves and have-nots)
        - Cadillac services for some while lower care for others
- Beds
    - Justification on the closing beds
    - Out of county placements due to the loss of beds
    - People pushed to lower level of care
    - Different level of care at CCRMC that is no longer there
    - Bed count
    - 10 remaining beds may be going away due to economies of scale (Acute care beds)
    - Nierika House
        - People are much worse off because their care was downgraded
- PHF
    - PHF – Assurances are given but later changed because of cost
    - Express the real worries of the PHF
- Ensuring good quality of life for consumers
    - Picking safe (internal and external)
    - Picking accessible outside resources (transportation and services)
    - Picking quality of housing
    - Subsidized transportation costs

Respectfully submitted,
Karen Shuler, Executive Assistant
Contra Costa County Mental Health Commission