

Supervisor Keith Carson, District 5
Howie “The Harp” Homeless Self Help Center Planning Panel
1221 Oak Street – Supervisor’s Conference Room Oakland, CA
September 10, 2009
1:00 pm – 4:00 pm
REVISED

Opening - Amy DeReyes, Health & Legislative Policy Analyst/ Supervisor Keith Carson’s Office

We are here today and for the rest of our scheduled meetings to work on developing a program that will bring the Howie “the Harp” Homeless Self Help Center (“the Center”) back in line with the state funding requirements. If we are not compliant with those requirements, the funding will go away as will the Center. It is our desire that the Center remain open to everyone. Thanks to all present here today for their commitment and willingness to participate.

We are very excited to have this very collaborative planning process and we hope to continue in the spirit that the Center was originally created. All participants are welcome to call the supervisor’s office with questions as we look forward to working with the planning panel.

Welcome - Colette Winlock, Health and Human Resource Education Center/Facilitator Introduction of Facilitators – I am Colette Winlock with the Health and Human Resource Education Center (HHREC), one of the facilitators for this process; Kirk Smith of Kirkland A. Smith & Associates (KASA) is the co-facilitator; Tisha Kenny, HHREC is Staff Support & Scribe; Sheila McWilliams, KASA Recorder; Marveta Allen, KASA Executive Administrator; and Robert W. Daniels, KASA Senior Consultant.

Colette - There has been a lot of anticipation around getting to this meeting. Supervisor Carson’s office received over 50 applications to participate, and quite a few consumers showed up today that were not selected to sit on the panel. This demonstrates there is a heightened expectation for continued quality services at the Center. In addition, there is a federal grant that specifically asks for services that would lead to consumer empowerment and transformation. It also calls for self help in this process, which will guide us to the language for Alameda County’s RFP process that will ultimately be issued. There are a number of providers in attendance and it is important to note that participation in the planning process does not inhibit you from submitting a bid once the RFP is out. Our goal is to create the best thing we know to continue to serve the people that utilize the Center.

Kirkland – KASA is a consultant firm that manages a full range of facilitation services and has worked with Alameda County previously in an African American Utilization Study with some of the participants here today. KASA is honored to be able to work in this venue with all the diverse representation here. We all have one common goal which is to serve to the best of our ability, encompassing the entire community and producing a great final product. Fostering team effort is encouraged by putting personal agendas aside to serve the greater good, the homeless and people that may need the services in the future to find a place within the Center that is beneficial to their situation.

Introduction of Planning Members and Alternates

Colette: Please introduces yourselves and give a brief statement on your vision of the Center

Planning Panel Members:

Kathy Zatzkin, System Liaison for Alameda County Network of Mental Health Clients -Long time member of the network. The words of the initial program description were sent to everyone here. Beyond that the real hope is to get back to the feeling of what the Center used to be many years ago. The focus was the same, but back then people were made to feel welcome and everyone had a place, it should return to this model.

Lt. Freddie Hamilton, Oakland Police Department – The goal is to help develop a model that will benefit the community.

Sally Zinman, Consumer Relations Alameda County Behavioral Healthcare Services (ACBHCS) – Felt obligated to apply to sit on this panel for Howie. Knowing the history of the Center, would like to see a consumer run program and get back to the core values.

Mike Church, City of Oakland Human Services - Works with the city to assess services such as outreach and would like to see more demonstrations of working together.

Sylvia McCain, Consumer at the Center since 1990- Hopeful to see the Center get a hand up not a hand out. Also would like to see more consumer involvement with the decision making process working along side the professionals, and working hand in hand together to make the community a better place for the consumer.

Abdul Kazeem, Consumer/Provider at the Center – A mental health board member and attends meetings regularly. Several hopes for the Center 1) to eradicate stigmatism; 2) bring out awareness wellness/recovery to all clients regardless of history; and 3) stop all the back biting that is going on through promoting negativity about what we are doing at the Center right now. The Center is well. We have to let go of old story telling, as there is nothing wrong at the Center and would like the County to see that component.

Anissa Williams, Neighbor and Family Member - Family oftentimes get lost in mental health. Has a son who suffers from bipolar disorder and would like to see the Center as a place where families can go in the community. Would also like to stop the mental health stigma (i.e. “oh that place”) and as a neighbor in the community would like to see the neighborhood partner with the County.

boona cheema, Consumer/Provider, Executive Director of Building Opportunities for Self Sufficiency (BOSS) – One of the people that started to meet with Howie and Sally in the early development of the Center, and was able to learn at their feet. Back then, resources for training were not made available and things could have been done a lot better with regard to the evaluation process. Would like to see all being able to walk into a center that is safe, where people know what they are doing, the roles and responsibilities well defined, and know they are in position there to build something strong which will edify those who walk in.

Cecelia (CeCe) Wynn, Consumer –Rehearing the history is great, but living in the now may be more important today. When Howie was alive he helped physically as well as mentally; has since had the opportunity to volunteer, to give back to the Center, which has been ongoing over the years.

Dayvell Rose, Consumer– Vietnam Veteran diagnosed with manic depressive schizophrenia in 1976; met Howie “the Harp” Geld in 1986. Howie was the first person that told him he was not different. There were more just like him. Howie encouraged him to make his own decisions around his treatment; has watched the Center change and go through some good things and bad things; would like for it to get back to what it was when “we” as clients were empowered by knowing this was our Center. Those then associated with the Center used to use the terminology “my center” but this language doesn’t seem to be used these days.

Reverend, Dr. Jasper Lowery – Clergy/fully recovered consumer and supporter - watched a family member go through serious AOD challenges that opened the door and allowed him to see the Center; states he is probably one of the silent people that worked along side of the Center in Oakland; has seen how people lives changed through its services (permanent housing, referrals) over the years; but has also witnessed the collapse of the Center and how some were unreceptive to any other ideas until now; waiting to see the next level of service using un-traditionalized ways like Howie used in the birth of the movement.

Planning Panel Alternates

Joseph Carter, Representative of the Center - Wants what is best for the Center and for the last 5 years served as a consumer supervisor; would like to see it to continue to be run by consumers, similar to the way it is now and supports anything that promotes progress in the neighborhood.

Ernest Hardmon III, Commissioner of the City of Oakland on Aging – Would like to see more resources and technology included in planning process; is on staff with the African American Male Issues Committee as well as the African Americans Speakers Bureau. There is a meeting on Sept 25, 2009, 9:30am, 333 Hegenberger, Oakland, CA. All are invited to come out and hear their stories.

Yvette McShan, Consumer/Client – Was a voice in 1997, but did not get recovery at the Center. Recovery was there, but she wasn’t ready to receive what was offered at that time. When recovery finally came (at another facility) went back to the Center and found it wasn’t the same. Would like to see the Center return to what it was like during the initial opportunity.

Summary of Introductions

Colette: One observation as we listened, going around the table, we’ve all verbalized a common goal for the Center. We all are adults looking for a good planning process. We wish to acknowledge the presence of the Center’s staff here and recognize in terms of listening and hearing some of the feedback about the Center. Going forward there will be no bashing of the existing services. Everyone brought their heart to the work as well as their best intentions and we are going to hold on to that. However, there is a need for all to be cognizant of the facilitators charge to keep the meeting moving forward respectfully. It is evident that the Center has impacted many lives in various ways. We must allow facilitators to move the process

forward respectfully, in order to be able to leave here in the next three meetings feeling satisfied that we have taken the Center to the next level.

In our planning process today, we have Gilda Mansour with ACBHCS who will present an overview of the Substance Abuse & Mental Health Services Administration (“SAMHSA”) grant requirements as we are working within some of those restraints in what is being asked of us today. We also have boona cheema with BOSS who will provide information on what consumer empowerment looks like and at the end of each presentation we will open the discussion to talk about what the model itself should look like.

In our second meeting on the 17th of September we will physically get into “what are the program components.” The 3rd meeting we are going to focus on the organizational capacities, meaning what are the values, the philosophies that are required for the organization to carry out these recommendations, what are the qualities of staffing we are looking for. At the end of these three meetings we will be able to go forward and give our recommendations to the County. Also worth mentioning is the community is waiting for the outcome of these meetings and are holding us accountable as well. Therefore, after we finish this process there is a community report back meeting, in which we have to take back to them what we’ve said and what we are recommending.

Rules of Engagement/ Kirkland A. Smith

A part of this planning process, we have to decide what the rules of engagement are *before* we get started as opposed to starting this process and then attempt to address potential areas of angst as they may arise.

- ✚ Panel Members Commitment – There is an expectation to attend and to participate in all meetings, but please communicate in advance if you are unable to attend. Colette is the primary contact for these purposes. The meeting dates were established to be every Thursday for the next few weeks here at Supervisor Keith Carson’s office. Our next meeting dates are September 17th and September 24th from 1:00 pm to 4:00 pm.
- ✚ Meeting Schedule and Agenda – All are asked to be committed to begin and end on time, and the agendas will be provided once you arrive. The challenge is for everyone to step it up to be on time. We realize there are lots of variables in our day to day activities and we encouraged everyone to do their best. The meeting minutes will be posted on Supervisor Carson’s and KASA’s websites and a hard copy will be given to you as well. You are encouraged to read the minutes prior to coming to the meeting in effort to maximize our time together.
- ✚ Meeting Format & Structure – It is our desire for everyone to freely participate as your thoughts and comments are wanted. Please refrain from sidebar conversations or texting as a common courtesy to others. This is a very diverse group of members here. Therefore, there will be different terminology used in communicating our thoughts. In order to be on one accord, requests for clarity may be asked of each individual and the use of acronyms is discouraged.
- ✚ Meeting Temperament – Mutual respect, no personal attacks, stay on task, sharing of thoughts without retaliation or embarrassment & more importantly respect our differences; any confidential sharing should remain within the group. There are no foolish questions.

- ✚ Meeting Content – Panel members will support the decisions and recommendations made as a group. Each meeting will have Q&A time to ensure harmony and unity (one accord).

In addition to the rules of engagement, the panel members are asked to be mindful of their language. It was recommended that we wear our Badges of Honor here. By submitting your application, you showed your desire to be a part of the team and are encouraged to do your best.

Substance Abuse & Mental Health Services Administration (“SAMHSA”) Grant Requirements Gilda Mansour/Alameda County Analyst

Background: SAMHSA funding is granted at the federal level and every year Alameda County Behavioral Healthcare Services applies for the block grant. It is my responsibility to compile the applications. Part of the money goes to the Center. The block grant is authorized by the public health act to improve mental health services. What does it (SAMHSA) do? It is supposed to reduce hospitalizations by implementing services in the community. Instead of experiencing a psychiatric emergency and having to be treated in the hospital; hopefully a person can be treated in the community. It also lends support to offer case management to individuals and address all of their needs, not just stabilization but day to day healthcare services; as well as support grass roots mental health movements. This grant is supposed to embrace these emerging practices.

Grant Award Criteria: In order to win the grant you have to be able to make proper screenings and referrals; with regard to case management, you have to be able to refer that person to the appropriate care and follow through; you have to be able to assess someone for their service needs, and try to work with other organizations that are working with these diverse populations and collaborate with other agencies so you are not sitting in a vacuum. The target populations are adults living with serious mental illness (SMI) or youth living with serious emotional disturbance (SED). You then have to create a plan to implement a program. With that you have to monitor that plan, evaluate it and finally report out to SAMHSA.

Block Grant Funds: We award \$700,000 to ACBHCS and it goes to various things like quality assurance, customer relations; outreach and advocacy as well as co-occurring initiatives. From that, \$119,000 has been designated to the homeless health center. An additional \$243,000 goes to the Center. Most of the money is from general funds which do not have restrictions, but it doesn't really matter because we are still funding it with the SAMHSA block grant money so the entire program has to fall under those guidelines. It really wouldn't make sense to say we are going to spend \$119,000 on all these guidelines that fit the SAMHSA block grant and do with the remaining \$300,000 whatever we want. For the sake of being simplistic and having an integrated program is why they should fall under there. SAMHSA block grant also asks “How are you auditing these funds” as it knows you cannot run a program on \$119,000.

The “Purpose” stated in the SAMHSA grant application year after year for the Center is

“Howie “the Harp” operates as a client run, self help program affirming the power of homeless individuals living with SMIs to assist and support each other in the pursuit of autonomy, equal justice, and financial independence.”

What this means is it is “peer led” – they are trying to help people help themselves through the knowledge of the community and through the knowledge of their peers - shared experiences.

The “Program Description”

“It’s located in West Oakland which provides a comprehensive network of services and peer support for individuals who live with SMIs, are homeless and may have co-occurring disorders.”

A co-occurring disorder is when you may have both a mental health issue and a substance abuse issue or a mental health issue and a physical issue – those types of things. We know you have to treat the whole person in one place with a comprehensible staff; rather than sending people to different places for treatment. The population is for adults living with SMI who are homeless or at risk of being homeless. They are marginally housed, or dangerously close to be living on the streets and with a verifiable current mental health disability and/or a psychiatric limitation.

Examples of program changes as to where this process can move:

- Holistic approach – Talk to family members and let them know they are included in the process. Program should promote understanding with family and consumers both which should also include:
 - Planning, implementation of the program.
 - Evaluation of peers and include different players in the program;
- Program should have the capacity to share mental health records of the consumers with the consumers and have the technology to make this easily accessible to them;
- Excellent mental healthcare is delivered and research is delivered –follow best practices, policy practices. The capacity to plan, monitor and change your program goals including documenting delivered services;
- Early mental health screening assessments and referral to services are common practices to be in touch with those in the community that can potentially help the consumers; and
- SAMHSA want to ultimately eliminate disparities in mental health (race, gender, demographic regions). This program should be able to properly identify the barriers to getting appropriate services and create solutions to those problems.

Questions – SAMHSA

Abdul: Does behavioral health reveal the application information to agencies and if you do how do you relay this information to the agencies so we know what’s going on.

Gilda: Good question... This may be public information since it is publically funded. I will have to check on and get back to you. It is a huge packet with program narratives and also has budget information.

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Dayvell: On the third page, you mention report out and meeting the needs – I’ve gone to certain agencies that referred me to another agency, but at the end of the day I really didn’t get any services except maybe a bus ticket from one to the other. But it’s being reported out that I’ve been helped. Who is monitoring this so that we know our monies are being spent properly?

Gilda: We've found a few issues with that. Your privacy is being protected. For instance when you receive a referral from someone to another agency, they can potentially follow up with that, but only in the capacity to determine if you actually showed up. The referring agency can't get information as to whether you'd received services.

Dayvell: What I am saying is, say for instance when I signed in and gave them the information, on the paper work it shows that I am another consumer they've helped. When in reality they've only sent me to another agency. This other agency does the same thing and refers me to another and yet another. At the end of the day I didn't get services at any of the agencies, but had been to 4. I usually end up back where I started from, or I am told to come back next week. On paper it looks like I got service 4 times when actually I didn't get any services. Who monitors these things?

Tisha: I don't have the exact answers, but all providers have to enter data as far as what we do. It is information dissemination and that's how it is logged and reported to the County each month to show what the agencies have been doing. As we are AOD rather than mental health, I am not sure about mental health. There is some record, but I believe what you are saying is at what point do they get into documenting actual services – Colette may have the answer to that.

Colette: I want to respond to what Dayvell is saying. I saw a lot of heads nodding when you brought that up. As a part of the process, we need to take a look at the effectiveness of monitoring the referrals and put in there that part of the RFP is "How do you do that?" Some of the questions that we are asking, we don't have answers to. Let's remember that we get to ask that provider that goes after this to tell you how they are going to monitor the effectiveness of the services.

Gilda: We hear this question all the time and it is very hard to track referrals due to a myriad of problems. But what you are feeling is real and that is why these goals have been set forth so the system can be transformed and you won't have to run all over town to do that. So how do you build the process that Colette stated which is to make people more accountable to these problems? SAMSA is aware and wants to see the accountability portion.

Mike: What are the matching funds of the grant, and two, have you considered cross leveraging with the MHSA and the McKinney funding?

Gilda: I am not sure about McKinney funds or how the director takes charge of those, but SAMHSA monies go through an elaborate community input process. Plans and strategies which are suggested go through an ongoing planning council. Those funds have already been allocated and if they haven't been slated for programs like this, it probably won't. With regard to matching funds we do for some at 2 to 1, but not all. I can probably see how much we've funded to other organizations and where their other funds come from, but it might take a long time. They still have to follow the same set of guidelines no matter how much funding they receive from the outside.

Mike: The reason I asked about MHSA funding is because that sort of connects the whole housing piece with a lot of the other services that get MHSA funds. It seems like it would be a good match

Gilda: It is possible there are some connections made. They may not be augmented by funds, but maybe some type of collaboration between organizations that are currently doing the housing piece. Again, I am not sure, but I know a specific fund amount will be allocated to this.

Sally: Instead of using the word “include” when talking about consumer family driven programs, I would rather the block grant language be upped from “to include,” to consumer family driven programs “shall lead.”

Gilda: The word “include” is taken right out of SAMSHA guidelines. You can go to the SAMHSA website and take a look at last year’s application package as this year’s package isn’t available yet – what their requirements are. A lot of that language is pulled out and relates directly to this.

Sally: Why are we limited to the word “include”

Gilda: Consumer family driven programs don’t pertain to all the programs we fund, that is why it is “include”.

Abdul: In response to what Dayvell and Sally said, as a provider, people tend to come back to me and let me know that agency told me, “I don’t live in that city”. Does MHSA have a particular program that entails other agencies to make sure we don’t have this stigma? When somebody gets mad, they can talk negatively about you. With all this commotion going on now, people that are not receiving services tend to go to different counties.

Gilda: This is why it is important for organizations to know the eligibility criteria for referrals. You don’t want to refer an individual to an agency that is closed. Building a system where you can know the referral processes because in some of the MHSA programs not anyone can just walk in. There are specific referral criteria and having a referral guidebook is important in making these recommendations.

Colette: We will bookmark the importance of how we look at the referral systems.

Rev. Lowery: My question is around all inclusive, off site and assessments into the budget. When talking about psychiatric assessments how close are we to trying to bring the clinical portion in-house? That is a budgetary item. Are we trying to do basic assessments or psychiatric evaluations?

Gilda: It doesn’t mean you’re doing a full psyche evaluation on a person, it means you need to be able to assess their needs. Maybe one of their needs *is* to receive a psychiatric evaluation; maybe you’ve assessed their needs and all this individual needs and wants is a bus ticket to and from work and they will be fine; maybe they need stable housing. This may be included in the menu of services depending on how you all shape what you think what this program will look like. I will follow up with Colette on the McKinney funding and give you the SAMHSA grant link where the application specifically sits on the SAMHSA website as well.

Abdul: When we talk about program description, it is important for us to know not everyone is homeless. I deal with this every day and it is very difficult. Many on street drugs have addictions and their addictions supersede the kind of services we can give them.

Collette: I hear you identifying a problem that you are working with. I am going to ask you to think through to a recommendation to address that specific kind of program in what we are doing here.

boona cheema, BOSS - Consumer Empowerment

Colette: We've spent time on what is our charge – what are some of the parameters. We are next going to talk about key elements in a self help consumer empowerment model that works for the mental health consumers and the homeless. When questions arise, jot down additional notes or questions for after the presentation based on what we have heard for the Center's RFP.

I would say boona has been very committed and innovative in what it means to create self help programs. What it means to involve people from the grassroots up. Taking a moment to hear from boona who is the Executive Director from Boss share with us her vast knowledge is around looking at consumer driven, consumer empowerment models.

boona: –I am thankful to be here. In thinking about what to present today, I decided in light of where we are today in the planning panel process for the Center is to make a generic, basic presentation on what the core competencies to run a successful consumer run program. I've worked in Alameda County on consumer movements not just mental illness but also youth programs as well as women living with and surviving

I've found at the core, consumer empowerment is that word in the middle, which is power. Consumers come together because they feel they don't have the power of making decisions in their lives, but feel they have the greatest information and knowledge to make the best decisions on how they live their lives, grow their wellness, enter recovery, and learn new skills to work. That's the level where discussion begins in consumer empowerment programs. They are extremely difficult to do.

The level of complexity of people coming to the table that have so little and also having people at the table who have so much power, the resources and the decision making authority part takes quite some time to bring the two sides together to come up with a model that will succeed for the people seeking the service. We can never take our eyes off the goal to create and make available the best services that we can. When we think about having that power and having that dialog, very quickly we are going to have to make a decision whether we are saying to the community we want a consumer run center. Or that we want a center that is blended, driven by consumers but the all decision making power is not necessarily in the hands of the consumer. Different structures can be created to make decisions and you can still take the decision, create a structure where nothing is implemented without consumer input. You can be very creative on how we set up the systems. I've seen quite a few models and can't say one model work better than others.

The decision needs to be made and brought to the table because when we get to the design factor for the center, there are going to be different elements in play. In designing a consumer run center, the RFP will say we are looking for \$400,000 and we want to create a consumer run center to provide these services. If it is truly consumer run, the consumer who applies for this may say "Wait, if it is consumer run, you've already made 80% of the decisions." There is a conflict here. You can't say you want a consumer run program and not really allow it to be consumer run. This is where the battles end up happening and that is also where sides get split. We could avoid that if we can become clearer about what we want.

The issues for any center is to be able to have its philosophies and values declared up front. You need to think about whether the people you are going to meet have cohesion around philosophy and values. Have I created a curriculum of core services such as providing case or money management, recovery, housing, or getting assessments? The curriculum piece is “What are they going to come here to learn so they can grow themselves and become the people who are then providing the services.” This core piece is critical to the strength of any center.

When developing new programs there is a tendency for people to want to be in the core piece... Is it going to be a closed Center, a membership Center, what kind of ground rules, and behaviors are there going to be? That stuff is really exciting.

The other side is what is sometimes forgotten and may be not as exciting. But this side is what makes it possible for the exciting side to happen. Components like what are your human relations pieces. What is your hiring and recruiting process, what is your pay scale, how do you discipline, is there enough equipment? Then the administrative piece, are your financial systems solid and in place? These are the things that don't involve a lot of people, except for the people who have to do them. At some point these pieces have got to come together, both services and methodology. The same values of fairness are just as critical in administration as they are in direct services of the center.

The orientation and training for all the layers of a center starts from leadership including staff to the person coming through the door. This is very important as well. We need to remember everyone has the capacity of being a leader in the capacity in which they are strong. Also, the same information needs to go to all of these people at the same time. At least through the development phase, everyone needs to know what's going on. It isn't always done like that, but this is what we must learn. Otherwise very early in the program there will be dissention. There are always predators to take what you got and to ensure that you are not successful. To involve everyone in the process so they have a place where the center is treating them with the same respect, the same dignity and ensuring the safety at the center is never at risk is a must. These community processes need to be addressed immediately, are ongoing and monitored with consistency.

When risky things come up they get dealt with immediately no matter the station (consumer, board of sups, whatever stakeholder). If we can't get solutions for our problems as people who run our center, how can we be expected to do a good job with the consumer and clients that come to that center?

We want to do everything for everybody. We don't have the capacity and I think it is unreasonable for a center with \$500,000 is expected to serve the entire city of Oakland's chronically mentally ill population. Whoever else comes to the door is setting that organization up for failure. There has to be adequate resources up front, an environment that can hold up to a certain number of people; staff that can only work with a certain number of people per day. With the volume of people coming in and out of the doors, security becomes an issue.

I am an optimist and believe this can be done very well with the people we have here to design a center. It would be great to know up front to know what kind of center, the target population, is it open to anyone, or is it open by some kind of referral, what are the expected outcomes.

Questions/ Consumer Empowerment

Mike Church: There are two sides to the structure that gets designed that I think we need to talk about. The one side is the programmatic side where the consumers have a voice and are empowered to run the center; and then there is the business side I am not totally clear about the current situation but I understand that a certain agent is identified as the fiscal agent.

Colette: Unless you're moving in the direction where you want to say we expect this kind of organizational capacity, it doesn't necessarily have to be identified as this agency or that agency. In order to facilitate the kinds of things that boona or we are coming up with, it is important that an organization has these kinds of capacities.

Mike: That's what I am trying to get at. We usually think of this as being in one entity that does the programmatic side as well as the fiscal agent side. But it doesn't have to be that way.

boona: In a true consumer run organization both sides are run by consumers.

Mike: And you think that is achievable in the short run of the RFP process?

boona: If it is not achievable in the first year it definitely is achievable over time. When you look at 20,000 chronically mentally ill people in Alameda County there are some folks with very, very high skills. They just haven't had the right opportunity to have those skills used in such a way that they've sort of lost hope of ever working. But we would hope there should be a place in that center where if you are employed as the CEO and you are a consumer, there is absolutely no reason that the CEO of this center couldn't be partnered with the CEO of let's say... the Bonita House. Utilizing a mentoring program – needs to be a bigger piece. There are lots of ways to promote self help.

Dayvell: You mentioned the power within and what I mostly heard was around leadership and accountability. It sounds real good and it sounds tempting. Is there really a model that is working now? It seems it works for a while and then after our leadership gets to a certain position, they are no longer held accountable. To me, it seems they lose focus and don't put their heart into it anymore. When you try to hold them accountable by talking to the people that are above them, it's hard for you to be able to get that opportunity to certain people in certain offices. You may be able to talk to their aides. This makes a person feel less than. How can we get this in play with the next RFP so the consumer voices can really be heard? It is written in almost every bylaw and guideline, when in actuality in the real world it is not happening. This is very sad.

boona: It's happening, but very slowly. I think the leadership of ACBHCS is committed to the systems change that's been asked, but I don't believe they have experienced going through such an extreme change that actually flips the system and puts consumers at the table that has never been done before. Consumers are entering the systems now, we're filling up chairs, but there is still a level where the consumer voice affects the decision making as much as someone else's voice, but we are not there yet.

Sylvia: I've been that consumer. I've been a participant of BOSS and other teams. Before becoming a county employee, I volunteered and helped to put a grievance system in place; I have limited education, but I've also worked with professionals that I thought were intimidated

by me. I only wanted to help with the consumer voice. I simply want to add a little enhancement such as street knowledge and perhaps Ebonics to give you more of an edge on how to deal with people on a different level. I learned life skills from BOSS and learned management of my mental health issues from another agency. I've utilized a little bit from each organization where offered. I think consumers and professionals can sit at a table together and make decisions together. If your goal is to become a consumer run program later on, we need the professionals in order to learn the life skills. We may need another organization to give us counseling experience. Everybody at the table - it takes a village. Just because we are adults doesn't mean we don't need the village too.

Kathy: In response to Mike Church's question, I work for the Alameda County Mental Health Network of Clients and our Director is a mental health client and she is a very wonderful fiscal specialist. Everyone financial statement should look so good – we don't have a lot of finances but what we do have is managed well. We're talking about generalizations and stereotypes. My point is you can't make assumptions at all.

Coming out of a truly client self help movement we still believe in client self help, but client run but as well. It is truly self help. Yes, there are some that used the model that were successful.

Lt. Hamilton: Is there a model or organization with structure in the Country? In almost every field there is a way that is recognized as the best to do things. Have we researched that to see if there is something we can learn from that center or program?

boona: There's many. We may want to take a week to do that. Another thing we may want to look at is that whatever center we look at isn't in Oakland. Oakland has some special design needs.

Lt. Hamilton: That model may already exist we might not know about it. Can we look at a city with similar demographics – maybe someone has already designed this. If this doesn't exist, maybe this is something we would want to incorporate into this program - that we are communicating our successes to other people.

Colette: You are aware there are a number in the Berkeley area that operates out of the model we are talking about today. Part of our charge is how we can take some of these existing program services and incorporate them into those particular best practices we need here.

Sally: Following up to what Kathy said. Whatever model chosen we want it recognized on the table there is stigma / discrimination that consumers can't do the work. I happen to know they can. Whatever model blended or consumer run this attitude that what consumers can or cannot do that informs your decision. There are some across the country that are very successful and operate with a million dollar or more budget in both blended and business models.

Collette: It sounds like we have a recommendation that we need to bring some of these working models to the table for review.

Abdul: How can you maintain the model with the curriculum you described when someone refuses to follow the rules of the center? They feel since they've lived at the center for

numerous years they are entitled to this center and don't want transitional changes. I have suffered attacks, discriminatory comments; bruises... people refuse to let others do what they are in line to do.

Colette: In focusing on this RFP, again think about how to best address the issues of stigma and bring back to the discussion next week.

boona: You're absolutely right there are a large number of people that live in that community. Every time a center opens in that community, they assume it is for them also. If we are going to serve strictly Alameda County's chronically mentally ill homeless folks a number of the community member might not meet the criteria. Where do we develop in the program how we let them know this center is really not for you?

Colette: There are a number of truths being spoken right now around what is some real issues providers face. That's a real issue.

Amy: From my perspective, we are really charged with not saying this should be a consumer run or this should be another kind of model. I think this is something the provider would identify in their proposal. I feel like we would be putting out what sort of programs we would be looking for in terms of the bare bone services and the things that need to be provided for the SAMHSA grant. The multiple organizations that choose to apply would themselves decide if there were going to be completely consumer or hybrid. I think we are taking away part of the decision making if we decide these particulars.

Rev Dr. Lowery – Doesn't some of those decisions come from the award grantee to set and choose the right people to put in place with the RFP specs – consumer ran?

Colette: We don't have to do the work of the organization that is submitting. We need to give them broad categories of what needs to be included in their types of services. We may want to work it out, but we need to come back to the broad category of services that will support the consumer driven piece; ensure empowerment activities and tell us what those activities will look like; philosophies and values the consumer can expect when they come in; what are the core services and curriculum; what is the human resource system and how to get to the expectations around hiring as well as what these categories would look like for that person - boona talked about all of these things.

Anissa: One thing I'd like to bring up is the orientation piece - from the very beginning. If all have the same training and orientation with regard to the center and what it will do, when everyone walks in you have respect for each other. Initial and refresher training should be implemented to ensure we carry on over the years and to foster accountability.

Sally: – I don't agree with Amy's comment. Whether it is consumer run or blended model, and these things are very key to the values and the philosophy. I think this is something this body should have input about and give to the community. In my mind this is what the RFP should say... this is for the community organization. The goal is within 2 - 4 years is that it will be given to a consumer organization.

Lt. Hamilton: If that is one of the recommendations this panel is going to have to make, how do we come to a consensus? Are we going to vote? How are we going to make those decisions?

Rev. Dr. Lowery: Shouldn't we be presented with a copy Howie's original program? Some of the answers to the questions here today can be found in the original vision. We understand without vision people perish. When we go outside the vision it becomes division and if we bring Howie's vision up to mesh with 2009 all the better.

Howie's vision was to operate as a client to run self help program, and per the 2009 homeless guide, there is a new voice crying from the wilderness and you have to be a wilderness person to understand what they are crying about.

boona: Howie would probably recognize we have a new community with new ways to serve them.

Colette: We can make sure when you leave here today you have a copy, we did mail these out. How are we going to make decisions? This planning panel is really putting forth broad and key recommendations to Alameda County to be included in the RFP. Mental healthcare are going to take our recommendations serious, but **THESE ARE RECOMMENDATIONS**. We as a group, as we continue moving forward, need to consider how much time should we debate on what recommendations should go forward? How do we respect everyone's opinion as to what is a key piece and consensus build around some of the priority pieces we want to see. These would be bottom line, what we'd deem as "MUST BEs" in the RFP.

In consensus building you'll have to ask yourself, is this something I can live with even if all of the things I'd like to see don't get in. Silent voices or minority votes will get captured somewhere in here too.

Adbul: Will addressing the incarcerated individual's needs to be included this in RFP. SMI and SED are not even there. These people are coming in for little stuff (a bus ticket); these are not services covered by the provider. So when we don't give them we are deemed as "no good". Establish a re-entry program – with components for mental wellness, as well as recovery.

Colette: Where do we go next? We need to start looking at what we need to see. We haven't worked out what kind of language to ensure the provider is moving towards a consumer run or an empowered program. Do we say you have to run this kind of program or that kind of program and allow the provider to tell us how they will get there?

Sally: Why can't we deal with this next week when we have models of either kind to make a decision? Maybe we may want to adopt the scenario Amy's stated where we allow the provider to describe how and what model they will use.

Kathy: It isn't what kind of program (blended / consumer run) that is important to me. It's when you talk about power. I wish for once this was spelled out. Are the services going to be for you as the client to have the opportunity to say "NO" to a service offered? Or are you going to be coerced into taking certain services and if you don't you will not be served – this is not choice. It needs to be up front whether clients or persons served have the opportunity to say "No" at all

without coercion. This should be key in anything we develop. We need to say this to the community as it is the most important thing as far as I am concerned.

Colette: boona also spoke about consumer empowerment and if we could come up with some guiding principles, an agency who submits would have to come up with how they would carry these principles out.

Dayvell: Who's going to do background checks or homework on those that submit applications to verify their integrity?

Colette: We may want to recommend to ACBCHS for a process that has consumer input around vetting

Sally: I propose in the next meeting, we started off with the model and go to the values and principle, then the week after than we could start plugging in the services and programs.

Anisse: I would like to see the co-occurring disorder piece get some attention. When people have substance abuse and mental health issues, neither of these illnesses can be cast aside when working with the other.

Closing comments:

Colette: Determine who the services are targeted for is one of the topics or agenda items for the upcoming weeks. Along with (recap of comments from various panel members):

- The 2nd week we will discuss the values/philosophy structure
- Addressing the emerging issues (re-entry; age based) to bring the Center current
- Sense of the demographics in terms of age (Amy / Colette) in Alameda County
- A couple of month of stats from the Center of who is being seen (Abdul) action item by next week's meeting.
- maybe bring in a variety of day schedules (Berkeley/the Center) to be brought in
- Picture of the area from a police perspective – crime, drugs, intoxication,

End.