WHAT FOLLOWS IS A TRANSCRIPTION OF THE DISCUSSION THAT TOOK PLACE AT THE EAST PALO ALTO MENTAL HEALTH ADVISORY GROUP MEETING REGARDING THE REDESIGN PROPOSAL PRESENTED BY STEPHEN KAPLAN.

Presentation Feedback: Ideas on Reorganization for BHRS - Steve Kaplan
- Steve gave the following overview of the BHRS Reorganization concept
  - I made a presentation back in February on reorganizing our services and unfortunately I had to leave so I didn’t get feedback from the group
  - I’ve been conducting about 14-15 of these presentations around the county and have gathered feedback
  - There are two webinars scheduled for next week where the presentation will also be given to be followed by a survey monkey for attendees’ feedback
  - We decided to conduct the webinars to provide opportunity for people who aren’t able to come to the presentations and for those who need more information
  - Invited everyone to join the webinar next week
  - Would like to review the presentation today before gathering feedback from the group
  - Jean asked about the Substance Abuse and Mental Health Administration’s (SAMHSA) “Good and Modern Addictions and Mental Health Services System” paper
  - Steve noted that the paper is worth reading
  - We had a retreat of BHRS managers and supervisors where we looked at the paper and compared ourselves to the concepts in the paper because we wanted to be as honest as possible about our work
  - We acknowledge that there is always room for improvement
  - From the first meeting it was asked whether we should divide up our services regionally
  - When we had our follow up retreat four or five years later, the idea came up again
    - We wanted to know whether it would improve what we do
    - This time we decided to explore it a little more
    - From all the listening sessions, we’ve gathered feedback from about 1000 people
  - First way to think of this community service areas will have a manager
  - Second way to think about it is how do we divide it up?

(Handed out three documents on the concept of community service areas and how it will work)
- Illustration of Community Service Areas and the Organizational Structure
  - Reviewed the illustration of the “Wellness Diamond” (left side of illustration)
    - Who we serve is everyone we serve now
    - Families are everyone we serve and who our clients feel is their primary support
We believe it is really essential as part of the recovery concept for everyone to be connected. The services that are provided are rooted in each community. We want to have the services be as relevant as possible to that community. Within each community, there would a diversity. Part of it is that the service system is reflected in that. The break in line reflects how easy it would be to get to the other services clients need and it's not linear. Inside the four areas will be everything we have to offer.

The Management Structure (right side of illustration)
- Each of the service areas will be like its own mini-BHRS with a service manager/director who will also be the single point of accountability.
- We’re imagining that within each of the service areas, there would be a planning committee as well as a mental health substance abuse recovery commission.
- We would say that 51% would be made up of clients, consumers and family members and they would have majority voting.
- The planning committee is an advisory group and it wouldn’t be policy making but their role will still be very important.
- It would also be a gateway and gatekeeper as far as access.

2) Community Service Area: Guiding Principles (from handout)
- BHRS works with communities to improve the health of individuals, understanding its influence in a person’s health.
- Behavioral and physical healthcare integration is key to ensure that all the clients' needs are met.
- Co-location of Mental Health and Substance Use services is in place whenever feasible.
- Same day access to services is provided.
- Peer and family support greeters/mentors help clients navigate services.
- The levels of care match the client needs (clinical or otherwise).
- Coordinated care plans across age and service boundaries are in place.
- Hours of service and entry points are flexible.

3) Community Service Area: Services to be Offered (from handout)
- Core set of services and supports common to all community service areas (CSAs), plus additional services as needed specific to each CSA.
- All needed substance use and mental health level of services: prevention and health promotion, early intervention, and treatment (all intensities).
- Referral and connection to other resources (housing, employment, etc.)
- Coordination of care between Primary Care and Behavioral Health
- Team-based care, including peers as members of teams
- Peer-run support, recovery and wellness services (adults, transition-age youth)

- Steve noted that after these listening sessions, BHRS will have another meeting to figure out whether we’ll move forward with this concept
  - Asked the group to give feedback on his presentation which will be recorded
  - Noted that he will not be able to answer any of the questions; he will just listen to the feedback and take it back to BHRS
  - Would like the group to answer the following four questions

1) What is your gut reaction?
   - Gloria noted that we need more details
     - Likes the connection; the concept is healthy, safe and open to a lot but the resources are important
     - We know we can’t have all that we want but it’s a step in the right direction
     - Not sure how connected it is to the core services agency but because of the relationship that has been developed here, it’s good
   - Gerardo noted that for FAL when it became the most effective for our clients is when they began the same day access services and if this is part of it, then it would be good
     - Incorporating services through substance abuse is very effective
   - Ray noted that the peer member and family involvement support is good

2) What questions do you have about it?
   - Faye asked what kind of training will be required within the designated services quadrants so that an individual coming into the quadrant will have effective intake and be directed to the appropriate place (for example, same day access)
     - Acknowledges that cultural competence is an important goal for BHRS but worries when it is not made explicit and how does it also become an important thread that undergirds the experience that people have when they come into the system
     - How does the management structure flow from localized service area to the leadership team at BHRS?
     - Does the service area manager have decision-making autonomy over the service area and what’s the connection to the BHRS leadership?
     - Do all the service areas have a body to participate in, in order for BHRS leadership to get an overview of the county operations or will they end up being separate silos?
   - Jean asked how BHRS will define each community service area
   - Faye asked whether there will be service providers in each community or maybe one for several communities
     - Added that assuming that this EPAMHAG process that we’ve been convening will transfer to the to its designated service area and its management structure, does the new structure relate to us in the same way we have been in the past several year?
Noted that the SAMHSA article talked about continuum of support beyond BHRS.
- How do you ensure that your wellness diamond has those components which are the extended services needed by the individual?

3) What’s missing from your point of view?
- Chester would like to see the spiritual component explicit.
- Gerardo would like to know who is going to be doing what, when, how and where?
- Rev. Frazier noted that when any new application begins, there is always a need for a lot of reinforcement and training because we all hear different and the clients are the most affected.
  - Would like to see training in every area reinforced and that we as staff understand the system so that we’re able to do what we’re supposed to do for one another.
- Ray would like to see the same training be available to peer support.
- Chester would like to know how it would address stigma.
- Carolyn would like to see how it would fit in with schools which she doesn’t see on the illustrations.
  - Also concerned about kids with disabilities who are under-identified which seems really disproportionate and agrees with cultural competency being explicit.
- Kacy noted that she wants to make sure that whoever is the service manager over each area is familiar with that particular community within that area and the culture of that community.
- Nancy would like to see the manager come from that community if possible because it would be a great asset since they would know the resources of that community.

4) If moving forward, what are two essentials we need to do to make it work?
- Chester noted that it would be important to continue to engage the community through the process in planning and implementation which has proved to be very rewarding.
- Faye noted that there has to be an element of accountability to the community.
  - There has to be a voice and something that will be more than a sounding board and a place where that management structure of decision-making is built in.
- Nancy added that it is important to stay focused and strong.
- Jean noted that it will also need to be accessible in all kinds of ways – conceptually and visually (if possible).
- Chester pointed out that accessibility and transportation will be important especially as services will be offered by one provider to more than one service area.
- Faye asked how the model of majority consumer and families (51%) has worked for BHRS.
- Steve noted that for federal boards, 51% has to be clients and consumers and that health centers should be rooted in community) - to the extent it has worked, we would assume it would be work here
- Rev. Frazier noted that the information given to consumers and planning committee should be representative of the community ethnically
- Faye noted that it seems like this is a relatively new concept in SAMHSA
- Steve responded affirmatively noting that SAMHSA was probably working on bringing everything together too
- Steve asked for others comments on the Webinars
  - Noted that we have no timetable for the implementation
  - We’ll identify the common themes from the feedback and if we decide to continue this process then we’ll start looking at the timetable
  - This is all self-imposed by BHRS by asking ourselves how we are doing and how we can do better
  - One of the questions we’ve come across during this process is whether this has been done somewhere else
    - I’m not sure if it would help to see if other places have done this because of different structures, funding, etc.
    - We think it would be more productive having these listening sessions and gathering feedback from the community
- Please stay tuned