

Mental Health Services Oversight and Accountability Commission (MHSOAC) Advocacy Contracts Meeting | October 6, 2015

Advocacy Contracts Project

Tuesday, October 6, 2015
10:00 AM – 4:00 PM
MHSOAC Office
Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

MEETING SUMMARY

Meeting Materials Available at: <http://www.mhsoac.ca.gov/>

- [Agenda](#)
- [September 22, 2015 Meeting Summary](#)
- [MHSOAC Contract Process - PowerPoint Presentation](#)

Introductions and Welcome

Sue Woods, facilitator, Center for Collaborative Policy (CCP) started the meeting and led participants in individual introductions. (See [Participant List](#)).

Opening Remarks and Structure for the Day

MHSOAC Executive Director, Toby Ewing, provided an overview of the project goals, including:

- MHSOAC (the Commission) has a statutory mission to support mental health advocacy among various demographic groups and constituencies.
- The Commission desires to create a shared understanding of lessons learned, create opportunities moving forward, and facilitate partnerships and collaboration between groups.
- The Commission wants to better align contract activities with the goals of the Mental Health Services Act (Act), prioritize transformation, and improve the overall system.
- The Commission cannot directly affect how all government listens, but can help support communicating messages effectively.
- A goal for today is to hear from participants about their priorities and experiences and to identify how lessons learned can shape the next round of funding.
- Dr. Ewing highlighted aspects of the contracting presentation and process including:
 - The need to ensure that discussions regarding the contracting process do not create a bias, making some participants ineligible for funding.
 - The Commission seeks to have the contracts in place by June 30, 2016.
 - Under new state-wide contracting rules:
 - All contracts will be easily accessible online.

- The Commission will make all deliverables available online so the public can identify how funds are spent.

Dr. Ewing thanked the participants for participating in the process and helping the Commission understand how to do a better job of meeting the goals of the Act.

Sue Woods reviewed the [September 22, 2015 meeting summary](#) and evaluations, the meeting materials, [agenda](#) for the day, and meeting guidelines.

Competitive Contracting Process

Norma Pate, Deputy Director, MHSOAC provided an overview of the anticipated competitive contracting process. See [PowerPoint Presentation](#) for details. Highlights from Ms. Pate's presentation are as follows:

- The Commission is recommending that solicitations are determined by the secondary Request for Proposal (RFP) process, which focuses on the highest scoring applicant. The Commission is:
 - Looking for unique solutions to identified issues in applications.
 - Resumes and reference letters for past work will also be required.
- There will be an example contract in the RFP.
- The Bidder's Conference is an important opportunity for applicants to ask questions. Ms. Pate recommended that applicants submit questions in writing to allow more time to respond. There is also a question period through email.
- Notification of Intent to bid is required for all bidders.
- Next step for contracts is development of an RFP and selection of Subject Matter Experts (SMEs).
- Anticipated dates for the contracting process are:
 - Request for Proposal (RFP) reviewed by Commission, January 2016
 - RFP released in February 2016
 - Scoring Process occurs April–May 2016
 - Contracts awarded in June 2016
 - Contracts begin in July 2016.

Questions and Answers

Scheduling and dates were determined to ensure contract continuity. Previous applications allotted 45 days to prepare and submit applications.

There was significant discussion regarding the selection of scorers; how scorers are selected, the criteria and eligibility of scorers, and how to prevent conflicts of interest. Discussion highlights include:

- Scorers will be SMEs experienced in the scoring process.
- The identity of scorers must remain confidential to prevent bias.
- The Commission will disclose what it is looking for and the scoring criteria.

- The Commission has not yet identified scorers. Scorers will not be Commissioners, but may include MHSOAC staff and previous contractors. Many details on the scoring process are not available until the RFP is released.
- Multiple participants expressed concern regarding the ability to identify neutral SMEs that have the requisite expertise and the cultural and community knowledge to understand client/consumer needs.
 - One participant stressed that identifying a SME that is a person of color will not ensure the requisite cultural competency for all communities.
- Attendees expressed interest in seeing the scorer criteria, but MHSOAC clarified that if participants reviewed draft scorer criteria they could become ineligible to apply.
- MHSOAC staff clarified that there is an in depth conflict of interest check for scorers to ensure a non-biased process. Attendees recommended that scorers consist of stakeholders from the relevant participant groups, but MHSOAC clarified that the scorers cannot consist solely of these stakeholders.
- One participant shared a positive experience as a scorer in a similar process, clarifying that seeing the scoring criteria helped in evaluating proposals.
- Dr. Ewing requested recommendations to ensure the scoring criteria is robust enough that the quality of the process is not dependent on the identity of the scorer. He asked whether there were questions to ask in the RFP to ensure applicants have an opportunity to describe the project activities needed for the specific communities served.
 - Commission staff confirmed that the scoring criteria will be available to applicants.
 - Attendees recommended that a representative SME have experience providing or receiving services within the community served and is not solely a member of the community.
 - One attendee recommended looking at the counties' scoring criteria as an example.
- One applicant suggested that the appropriate questions will vary depending on the type of contract and services being requested and the consumers served.

In the RFP process, every applicant must meet the minimum qualifications and will receive extra points for meeting desired qualifications. Subcontracting will be permitted to meet the qualifications.

Contract Management Strategies

Angela Brand, Staff MHSOAC reviewed contract management lessons learned from interviews and previous sessions. She shared the following suggestions received from contractors:

- Digital drop boxes are preferable to bulky email attachments.
- Streamline email processes. For example, all deliverables are sent to one email address, not tied to one staff person.
- Those awarded contracts should have direct contact with the contract department to ensure immediate responses relating to contract awards and commencement of the contract process.
- Ongoing communication between contractors and MHSOAC provides opportunities to assess and share the success of activities and provides a chance for course correction, when needed.

- Coming together helps the Commission staff and organizations discuss ways to improve the overall experience: organize meetings among contractors to share work being done, identify opportunities to work together, and share successes, best practices and resources.
- Increase opportunities to share work with the Commission and others through a shared calendar of events or trainings, or offering presentations to the Commission on projects.
- Staff also shared an interest in going in the field to see progress in-person and attend community events.

Questions and Answers

There was a discussion on the pros and cons of various funding mechanisms.

- Some participants expressed anxiety of being in arrears with the deliverables and reimbursement processes.
- One participant shared the process one county uses that allows for a 10% advance on funding.
- Another attendee recommended the availability of seed money in a deliverable process.
- MHSOAC staff suggested a hybrid process and clarified that different funding mechanisms work better for different types of activities.
- MHSOAC clarified that a loan process is something that would take time to create.
- One participant suggested that the funding mechanism discussion requires additional time.
- Several participants recommended flexibility in the funding process to fit different organizational needs.
- One participant recommended offering administrative costs at the beginning of the contracting process.

There was additional discussion on contract documentation.

- One participant stressed streamlining the documentation process.
- Commission staff clarified that deliverables are usually a documented item, required in an auditing process. One participant expressed support for the level of documentation currently requested by MHSOAC.
- One participant offered a recommendation for preparing documentation other than in a written format, e.g. use of video and audio.
- Dr. Ewing emphasized the importance of creating deliverables that are valuable to the work and not solely about meeting a reporting requirement.
- Another participant expressed concern that results metrics for advocacy are very difficult to document.
- MHSOAC staff recommended that the current process allows bidders to identify which strategies are effective to accomplish goals. This will give contract holders an opportunity to identify creative strategies for documentation.

Activity #1 and Discussion: Identification of Capacity Building Needs

Participants identified and prioritized what they needed for their organizations to be successful. This exercise provided ideas for consideration, but it was made clear to participants that there was no guarantee that the services will be provided.

MHSOAC clarified that these items are intended for all advocacy groups in attendance regardless of whether they receive a contract through MHSOAC. Participants' suggestions during the discussion and from past interviews were listed on flip charts. Each organization/individuals represented had an opportunity to rank their top nine capacity needs. The suggestions offered and the participant rankings are summarized below:

Capacity Building Suggestion	# of Dot Votes
Cross-training (perspectives/ across stakeholder groups) <ul style="list-style-type: none"> For example, client culture and diversity competency trainings. Opportunities to train each other, facilitated by MHSOAC. Co-training includes development of trainings together. 	7
Sustainable Funding/Financing	6
Evaluation/ Reporting (tools)	5
Policy development and monitoring <ul style="list-style-type: none"> This included translating policy information to lay people and making it understandable and more accessible to communities, including adding cultural and geographic relevance. This may also include demonstrating how state and local policy decisions and information are relevant to the daily life of consumers/clients. 	5
Operationalizing transformational strategies <ul style="list-style-type: none"> Values, understanding, practices in the field 	5
Facilitating Partnerships	4
Membership Development	4
State/ Local info dissemination	4
Grassroots Development	4
Research and Data	4
Strategic Planning	4
Legal Help <ul style="list-style-type: none"> For example, the legality of meeting waivers for youth meetings 	3
Resource sharing	3
Board Development	3

Capacity Building Suggestion	# of Dot Votes
Social Media use/training	3
Marketing	3
Staff Development	3
Revolving Loan Fund	2
Personnel and HR Training	2
By-laws	1
Management Skills	1
Budgets & Accounting	1
Grant Writing	1
Graphic Design	
Website Development	
Technical Writing/ Editing	
Business Plans	
OAC List Serve access/ Org List Serve <ul style="list-style-type: none"> • Sharing contact lists for outreach • Networking • Sharing contact lists among groups within similar fields 	

Dr. Ewing emphasized that the participants and organizations represented within the room have more resources collectively than the Commission alone. MHSOAC can facilitate the sharing of resources, but capacity expansion requires partnership and collaboration among all groups.

Discussion/Activity #2: Strategic Investments: Areas of Greatest Need by Population group

Working in small discussion groups, participants first identified the needs of each population group. In a large group effort, participants then organized and clustered the identified needs. Participants identified their priorities by the number of dots placed by each need or cluster of needs. The population groups discussed were:

- Transition Age Youth (TAY)

- Children/Youth
- Consumers/Clients
- Families
- Racial/Ethnic
- Veterans

After the needs were ranked, participants reviewed the top ranked need for each group. In brainstorming sessions, participants discussed the types of activities recommended to address those needs. Many of the groups prioritized peer to peer support as a need. Participants discussed peer to peer in general and agreed that this qualified as both a need and an activity. Therefore, the second highest ranking need after peer to peer was discussed during the brainstorming sessions. The brainstorming results for each population group are summarized following each table of identified needs.

Note: needs below were written by the participants on post-it notes and transcribed verbatim. Needs were grouped by the participants. Each grouping is separated by a blank row.

Transition Age Youth (TAY)

TAY	
Needs Identified	# of Dot Votes
Mentorship	8
Advocacy Training	3
Leadership Development	1
Housing Education and employment	5
Engagement and outreach needs to be in youth’s language / Make information culturally relevant to youth	4
Normalizing receiving of special messages “psychosis”	4
TAY- before Stage 4 services	3
Specific outreach to foster youth	2
Youth/young adults need a way to access services through schools. (Not necessarily at schools.)	2
Access to treatment during emergencies	2
More PEI services/ strategies	2
Need to engage LGBTQ around mental health wellness	1
School-based mental health services access	1
Educate public on why TAY is a separate and unique group	1
TAY- driven engagement strategies, activities for decision making	1
Educate public about advocacy PEI	1
Educate TAY at their user level (social media)	
Educate general population about anti-bullying needs— connection to mental health	
Bullying issues amongst youth/ young adults	

TAY	
Needs Identified	# of Dot Votes
Education about how to access services	
Inequitable resource allocation	
Timely access to treatment	
Transportation to services	
Ensure access to services is not infringed by economics	
Neutral forum to share ideas across groups	
Self-sufficiency	1
Recognition of self-reliance	
Support for self-reliance transition	

Mentorship was the need ranked highest for TAY. During the large group discussion the participants brainstormed some of the activities and methods to address this priority need. Below is a summary of the suggestions offered by participants.

- Leadership development programs
- Finding mentors
- Outreach for mentors and mentees
- Pairing older mentors with TAY
- Pairing like-minded people (i.e. similar backgrounds and experiences)
- Collaborate with other organizations serving TAY, including those outside of mental health organizations
- Peer to peer mentoring training
- Funding to support activities
- Identify outcomes that are mentee driven

Children and Youth

Children and Youth	
Needs Identified	# of Dot Votes
Education to service providers: <ul style="list-style-type: none"> • Diverse entry points • Family entry points Education to parents re: three levels (tiers) to advocacy	7
Peer to peer services	6
Peer to peer support/ support for parents	1
County relationships	6

Children and Youth	
Needs Identified	# of Dot Votes
State level advocacy	3
Advocacy training	3
Knowledge of reducing disparities	4
Empowerment for parents	4
Reducing of stigma recovery concept	3
Knowledge of available local services	
Respectful trusted care	3
Recognition and representation at the policy decision-making table	
Coordinate with other sectors. (Educational, juvenile, etc.) Local, state, social, faith based	3
Neutral forum to share ideas across groups	1
Community based advocacy	1
Access to services not infringed by economics	2
Address delayed/early identification	2
Place to meet and share experiences (conference, meeting) cross-group outside standard circle	1

Education was the highest ranked need for the Children and Youth group. During the large group discussion the participants brainstormed some of the activities and methods to address this priority need. Below is a summary of the suggestions offered by participants.

- Integration of mental health into the school curriculum
- Promote mental wellness
- Educate students on how to address mental health, wellness, mental-health issues and concerns
- Anti-bullying education
- Understanding and normalizing mental health experiences (i.e. psychosis)
- Suicidal/ self-injury awareness and prevention
- Training to parents (including foster parents) on mental wellness
- Child welfare system navigation
- Culture/ethnic studies (including LGBTQ)
- Mental Health Bill of Rights
- Policy/advocacy education – how to conduct, what it includes, etc.
- Explaining the three tiers of advocacy:

- Local (with family)
- Community
- State/Federal
- Funding to support activities

Families

Families	
Needs Identified	# of Dot Votes
Peer to peer support	7
Stigma discrimination and reduction	5
State-wide voice and statewide programming	4
Trainings for families to navigate systems (juvenile, education/ school, state level)	4
Diverse family structures	3
Training to families, legislatively, consumers, etc.	3
Racial/ethnic identity advocacy	3
Training on how to partner together (families and consumers).	3
Cultural awareness	2
Need for families and consumers to do cross collaboration	2
Outreach and engagement	1
Advocacy training	1
Neutral forum to share ideas across boards	1
Self-sufficiency	
Veteran family support both ways (support to families, training families to support Veterans)	
Address the fear in acknowledging mental health issues (i.e. fear that acknowledging mental health issues may result in losing children to welfare systems)	
Access at all hours	3
Access to services	1
Access to services in emergency situations	1
Access to services not infringed by economies	1
Access to resource stipends does not have an impact in services	
Appropriately trained people (service providers, police, etc.)	3
Reduce financial barriers to services	1
Translation and interpretation services	1
Respectful trusted care	
Timely access to treatment/ access to services	1
Guilt/blame reduction (identified during brainstorming session)	

Stigma education and reduction was the highest ranked need for the Families group. During the large group discussion the participants brainstormed some of the activities and methods to address this priority need. It was discussed that stigma discrimination can be against families as well as individuals. Below is a summary of the suggestions offered by participants to address stigma and discrimination reduction as it relates to families, including stigma against families.

- Education to editorial boards of newspapers and representation in media that articulates mental health issues in a non-discriminatory way.
- Training:
 - In schools about language that perpetuates stigma
 - Education of culturally specific ways to look at mental health experiences (different cultures discuss it in different ways).
 - Training for mental health and health care providers.
- Culturally appropriate prevention services
- Culturally appropriate early intervention strategies
- Peer to peer support groups
- Public education regarding how experiences vary depending on one’s cultural lens
- Funding to support activities

Racial and Ethnic

Racial and Ethnic	
Needs Identified	# of Dot Votes
County relationship	6
Reducing power dynamics	2
Recognition and representation at policy making table and advisory committees	4
Advocacy services	3
Advocacy training	2
Peer driven services	5
Peer to peer support	3
Culturally specific services treatment	4
Access that is specific to population	
Training should be population specific	
Cultural competency	3
Cultural and linguistic competence	2
Translators and interpretation. Everything including at service points	1
Transparency from counties about which groups are being served	3

Racial and Ethnic	
Needs Identified	# of Dot Votes
Introducing cultural services or practices to diverse communities.	1
Recognition of cultural differences	
Strengthening understanding of culturally diverse practices	2
Community defined practices funded	2
Culturally powered process	2
Self Sufficiency	
Reducing of stigma recovery concepts	4
Access to services not infringed by economics	3
Education to consumers about services	3
Education to families about services	
Education to service providers at diverse entry points	1
Respectful trusted care	2
Access during emergency situations	2
Timely access to service	2
Address delayed availability of treatment, follow-up (wait lists)	1
Neutral forum to share ideas across groups	1
Knowledge of available services	

The grouping of advocacy for mental health services was the highest ranked need for the Racial and Ethnic group. During the large group discussion the participants brainstormed some of the activities and methods to address this priority need. Below is a summary of the suggestions offered by participants.

- Training designed specifically to community members and to decision-makers, including
 - Education on cultural humility
 - Funding needs
 - CLAS standards
- Training materials
 - Developed and reflected by populations
 - Materials in needed languages
- Safe-space community forums

- Permanency in services (funding)
- Recruit diverse leadership
- Education on self-sufficiency/ empowerment
- Training to reduce self-stigma/ cultural stigma
- Funding to support ongoing activities

Clients/Consumers

Clients/Consumers	
Needs Identified	# of Dot Votes
Legislative advocacy	6
Information and education about consumers to the general public	3
Cultural competence and awareness	3
Education to policy makers	3
Respectful trusted care	2
Education to consumers about issues	1
Self-sufficiency	1
Peer to peer support	6
Stigma reduction	5
Strong leadership & voice	5
Healing a community	5
True transformation (recovery/ mental health places)	4
Equity of services	2
Service monitoring	1
Neutral forum to share ideas across groups	
Service delivery	
Access during emergencies	4
Outreach and engagement	4
Accessibility of services	2
Organizing people together for collective activism (w/ nuance) (Ensure that collaboration and organizing of different groups does not filter out or dilute the nuances necessary for specific groups (i.e. the nuances of care and services needed for veteran's families versus racial/ethnic families.)	2
Connection of local to state	2
Advocacy training	2
Access to services not infringed by economics	1

Legislative advocacy and education to policy makers was the highest ranked need for the Client/Consumer group. During the large group discussion the participants brainstormed some of the activities and methods to address this priority need. Below is a summary of the suggestions offered by participants.

- Organize consumers to attend hearings, etc.
- Elect consumers to office
- Educate consumers on policy issues (subject matter) and processes
- Leadership development
- Develop relationships with policy-makers
- Anti-stigma education to policy-makers
- Coalitions among mental health organizations
- Funding to support activities

Veterans

Veterans	
Needs Identified	# of Dot Votes
Understanding the needs of veteran's family members	7
Transition from active to civilian (This differs among military branches)	3
Address honorable vs. dishonorable	2
Addressing the guilt of war	
Peer to peer services	7
Respectful trusted care	
Trauma	5
Need for better advocacy for medical and social services	3
Advocacy training	1
Veterans' stigma reductions	5
Veterans' long-term benefits	3
Policy of no wrong door Get walked to another door (i.e. if a veteran is not eligible for services at the branch or location they go to, they are shown the correct location to get needed services versus being turned away.)	4
More VA care in all regions	4
Establishing a timely access and link to services <ul style="list-style-type: none"> • Access to services • Timely access to services 	3
Timely access to treatment <ul style="list-style-type: none"> • Appropriate referrals to mental health resources 	2
Ownership and understanding of veteran's needs and ability to address those needs.	2
Access to services not infringed by economics	1
Educating mental health providers	3
Education on military cultural competency	1
More understanding and education about mental health services.	1

Veterans	
Needs Identified	# of Dot Votes
Consumer education about no closed door policy	
Resources~ public education and success gaps.	
How to help people in a benign way for clinicians	
Veterans making services non-coercive so people feel that they can get help/assistance!	2
Community at services (deployment, service, branch)	2
Veterans diversity in the military	1
Coordination services (housing, etc.)	
Trust of services	
Neutral forum to share ideas across groups	
Transition to limited reliance on services	1
Supporting self-help to leave "services" independent living	1
Recognition of self-reliance	
Self sufficiency	

Services to Veteran’s families was the highest ranked need for the Veteran’s group. During the large group discussion the participants brainstormed some of the activities and methods to address this priority need. Below is a summary of the suggestions offered by participants.

- Outreach to families
- Connect veteran’s families to existing mental health networks
- Peer to peer and family to family support
- Training and education to families on:
 - Grief and loss
 - Navigating the system
 - Available services and assistance with transition of returning service members
 - Stigma reduction
 - How advocacy works and how to engage in advocacy efforts
- Case management for families
- Education and communication to large mental health providers on the needs of families
- Inclusion of authentic family perspective to mental health advocacy discussions
- Funding to support activities

Time was not available to review some of the barriers associated with the foregoing strategies. Ms. Woods recommended that participants consider and identify potential barriers in their applications.

Closing Discussion

Participants were reminded to fill out the evaluation packets to assist organizers in next steps. Dr. Ewing acknowledged that he had not seen this level of collaboration and sharing of ideas between these groups before. He thanked participants for their participation and dialogue.

Closing Comments and Questions from Participants

Participants thanked the MHSOAC for having these sessions and acknowledged that they felt heard.

Multiple participants acknowledged that the handout showing contractor's current funding was a good example of transparency.

Participants indicated that they learned methods for collaboration through the meeting facilitation.

Participants acknowledged that the overall meeting process made something complex feel more comfortable and interesting. They also thanked the Commission for the opportunity to speak with one another and start the process of leveraging opportunities and working together.

Dr. Ewing acknowledged the desire to create awareness of the process and understanding of why the Commission is making this shift. The overall goal is not just to raise the bar for competition, but to give organizations more freedom to propose things that they are excited to do and they feel will improve access to services, responsiveness, and creating a positive impact.

Meeting Attendees:

Zima Creason, MHAC
Haydée Cuza, PEERS
Daniel Domaguin, CRIHB
Tando Goduka, CAMHPRO
Chuck Helget, CAVSA
Michael Helmick, REMHDCO
Stacie Hiramoto, REMHDCO
Jackie Jimenez, REMHDCO
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