MINUTES – Mental Health Services Act (MHSA) Steering Committee 03/28/2018
Location: Eric Rood Center, Providence Mine Room, Nevada City, CA

A. Welcome & Introductions/Announcements

The meeting was called to order by Michele Violett. Self-introductions were made. A sign in sheet was placed on the table for all to sign.

B. Public Comment

Shera Banbury Thanked Michele Violett for her work as MHSA Coordinator. Theresa Hodges commented that she is grateful for MHSA funds that have made it possible to have the Insight Respite Program. The respite program has touched a lot of lives and she is grateful to be a part of it. Theresa Hodges thanked Michele Violett for everything she has done.

C. Interim Director of Behavioral Health – Phebe Bell.

Phebe Bell is learning the Behavioral Health Department, Western Nevada County and programs including those of our community partners. Phebe Bell is also learning how unique Nevada County's Behavioral Health Department is as compared to other County Behavioral Health Departments; we rely heavily on our community partners. It allows us to be more deeply connected to the community, more nimble and broadens our reach.

Behavioral Health has received a large grant that will allow us to remodel Odyssey House. Behavioral Health did not receive a grant that would have allowed us to fund a crisis mobile response team.

Work has begun on next year's budget. The State budget is in good shape and revenues in general are up. Part of Behavioral Health's budget comes from the State. There are four funding streams that make up the Behavioral Health budget: Mental Health Services Act, 2011 Realignment, 1991 Realignment and Medi-Cal billing for services provided.

Impacts to the Behavioral Health budget. The State transferred financial responsibility for In Home Supportive Services (IHSS) to the Counties. Any growth in Realignment will fund (IHSS). AB1299 presumptive transfer. Mental health service needs for children placed out of county in residential placement become the responsibility of the receiving County. Nevada County has 50 – 60 beds. The State is working to ameliorate the fiscal impact by having the sending County offset the cost. Organized Delivery System (ODS) expands Medi-Cal for alcohol and substance use services. All Medi-Cal recipients have a right to alcohol and substance use treatment services. Behavioral Health is concerned about the cost to match Medi-Cal with the increased demand for services. SB82 grant funds ($700,000 per year) end this year. This grant helps fund the CSU, Insight Respite and crisis staff at the Emergency Department 24/7. Our goal this year is to maintain services at existing levels.

D. Annual Mental Health Services Act (MHSA) Plan Update to the Three Year Plan and the Annual Progress Report for Fiscal Year 2016/17 – Michele Violett. Handout.

Included in today's handouts is a copy of our Mental Health Services Act Annual Update for Fiscal Year 2018/19 and the Annual Progress Report for Fiscal Year 2016/17. State regulations now require that we have our MHSA Plan and Annual Progress Report submitted by June 30th of every year. This is a very tight timeline to gather MHSA data and turn it into a report. If we do not meet this timeline the State can withhold 25% of our MHSA funds.

AB114 relates to MHSA funds that have reverted back to the State, that were reallocated back to the counties. See pages 74 and 75. The State has not given counties regulations on how to track reverted funds. Fiscal staff has not completed the cost reports indicated by the blackened area on page 75. We are required to submit a plan to expend any reallocated funds. For Community Services and Supports (CSS) any reallocated funds will be spent on existing CSS programs and will be the first funds used. Innovation funds will be spent on our current or next approved Innovation Plan. Prevention and Early Intervention (PEI) if any funds revert they will be spent on programs in our MHSA Three Year Plan. These funds will be the first funds spent. Nevada County's MHSA Plan includes a statement that any CSS funds that are about to revert will automatically be put into prudent reserves. CSS is the only program that we can do this.

Michele Violett reviewed the changes that were made to our MHSA Plan.
We have added $14,200 to our prudent reserves. The history of our prudent reserve fund is on page 25. When MHSA began it was recommended that we keep 50% of one year's MHSA funds in prudent reserves. Currently we do not have 50% of one year's funds in reserve. MHSA funding varies from year to year and we use prudent reserve funds to keep existing programs funded.

There was a name change from Homeless Rapid Re-Housing Program that Turning Point is implementing with Hospitality House to Housing Assistance Program.

There was a name change from the Social Outreach Nurse Program to the Social Outreach Program.

Included in our MHSA Plan is an estimate of how many people we will serve and an estimate of costs. In the past Michele had separated Eastern and Western Nevada County. We are no longer separating this information as there is a concern that if we say we are going to serve 50 people in Truckee and 150 in Western Nevada County we will be held to these numbers.

The Mental Health Services Act Steering Committee has created an MHSA recommendation of needed mental health services. Included are Truckee recommendations of needed mental health services. The Community Collaborative of Tahoe Truckee worked on this list of needs for the Tahoe Truckee region. The needs list can be found on pages 76 to 80.

The Annual Progress Report is Exhibit G on pages 81- 200. Michele Violett thanked everyone for collecting and reporting demographic and outcome information.

Michele Violett asked if we can move the plan forward and reviewed the next steps. The MHSA Plan Update and Annual Progress Report will be posted for 30 day public comment period. Next will be a public hearing at the Mental Health Board Meeting. The MHSA Plan Update and Progress Report will then go to the Board of Supervisors for approval. The MHSA Plan Update and Annual Progress Report will be given to the Mental Health Services Oversight and Accountability Commission (MHSOAC) to post on their website.

Michele Violett asked if there were any comments on the plan.
Hellen Williamson appreciates Michele Violett and what it takes to complete the MHSA Plan. There was another comment from someone who loves the program participant stories; they bring it to life.

Michele Violett asked if there was approval to move forward with the plan. The MHSA Steering Committee agreed to move forward with the MHSA Plan. No one was opposed.

E. Innovation – Michele Violett.

Behavioral Health has approximately 1 million dollars for Innovation Plans. At the October MHSA Meeting there was discussion on Innovation Plan ideas. Michele Violett has also received emails with Innovation Plan ideas. Most of the ideas that have been suggested have to do with the homeless population. Brendan Phillips, Housing Resource Manager with the Health and Human Services Agency has been researching what it would take to have a mobile home park or tiny homes for the hardest to serve homeless individuals who may not be served by Hospitality House. There are also a lot of community organizations that are working with the homeless individuals who do not participate in county run programs. Our Innovation Plan would have to be approved by the MHSOAC. It is urgent that Behavioral Health get an Innovation Plan approved or Innovation funds will revert on June 30th.

Shera Banbury supports the idea of tiny houses and also expanding SPIRIT and providing them more funding. Michele Violett mentioned SPIRIT is an existing program, so it would not be considered new or innovative and would most likely not be approved by the MHSOAC.

Innovation funds are limited to a maximum of 5 years and we need to keep in mind that we would need other funds to support it in the future. It would be good if we could purchase a building then the main costs would to maintain it.

F. Small Group Activity.

Michele Violett asked everyone to break up into smaller groups.

a) Share what you are proud of about MHSA programs (can be a place you work, a place you received a service, a training you received or a program you heard about from another person).
b) Share what you see as the change in the Mental Health System as a result of MHSA.
c) What do you see or hope for the Mental Health System as a result of MHSA in 10 years.

G. Report from Small Groups.

Group 1:

a) Turning Point, Laura's Law, Collaboration, bringing individuals from out of county locked facilities back to the community with supportive services. Providing a housing option that is staffed 24/7, housing for 34 individuals through master leases.

b) 211, Coordinated Entry, Insight Respite, CSU, better relations with law enforcement, increased community based mental health services, more collaboration among community partners, homeless outreach, forensic outreach, shift from a medical model to a recovery model, and increased trainings.
c) Crisis residential, medical respite, mobile crisis, wet shelter, affordable housing, stigma reduction, increased peer support funding, day center for homeless individuals with case management services, medical assessment and therapy.

Group 2:

a) Incorporation of the MHSA five essential elements into the culture of the mental health community.
b) The focus on consumer and family voice, community responsiveness, stakeholder involvement in assessing needs, increase in intensive and integrated services, opportunity to learn and improve understanding of mental illness and health, MHSA sponsored trainings elevate collective knowledge, eastern and western county connection, improve communication and collaboration between stakeholders, huge system growth around suicide prevention, intervention and postvention.
c) Addressing and seeing behaviors as symptoms, universal language countywide, continue de-stigmatization of mental illness, increasing understanding of brain disorders, neurobiological underpinnings of serious mental illness versus DSM approach, research, more in-depth assessment, genetic predisposition, more substance use disorder funding, eliminate separation of funding streams (mental health vs. substance use).

Group 3:

a) Second Step Program – prevention pre-school age, Latino outreach, Crisis Stabilization Unit, Insight Respite Center, Peer Support Specialists Programs at Behavioral Health and SPIRIT, WRAP (wrap around services), Moving Beyond Depression Program, and 211
b) Increased collaboration resulting in a more robust safety net, increase of awareness and de-stigmatization of mental health issues out in the community, ability to serve more broadly and deeply through increased coordination and increased funding, deeper understanding among service providers of the array of mental health issues.
c) Increase in childhood mental health services resulting in a reduced need for services as adults, Nevada County as a trauma informed community, community members of all ages and groups know about all mental health resources in the community, more in schools supports – behavioral support specialists in the schools to help teachers who are reporting more challenging behavior.

Group 4:

a) Training - WRAP, Peer Support, Mental Health First Aid, Suicide Prevention; bilingual mental health services both in western and eastern Nevada County. Networking between agencies, 211, wrap around services (Victor, Turning Point), Respite Center, Crisis Stabilization Unit, youth services in schools (groups & screening), Friendly Visitor Program, Moving Beyond Depression, and Hospitality House.
b) Behavioral Health grew from outpatient programs and crisis services to a more comprehensive array of services (more partnerships, collaboration, multi-disciplinary teams, wrap around, integration in schools). Less stigma, more awareness of mental health issues, peer support, consumer voices, consumers participate in the planning process, person centered services, prevention outreach, early intervention for psychosis.
c) Decrease in homelessness, tiny house village, crisis stabilization and residential treatment for youth, more services navigators, employment services – alliances with local businesses and supportive coaching, trauma informed system across disciplines, senior in home care, a campus of services co-located, increased access to substance use treatment, more integration with mental health and substance use, parole transition support, and more access to mental health in schools.

Group 5

a) We value the consumer voice, we have a lot of programs for a small county, prop 63, transformation of our systems from medical to recovery model, proud of collaboration between agencies – shared learning. Prevention activities – especially for mother/baby population, Nevada County's support of Laura's Law – Assisted Outpatient Treatment. Seeing consumer outcomes – consumers are getting better, recovering and have support. Best practice trainings available for staff, using evidenced based practice is more common now.
b) Electronic Health Records – reporting data we did not have before. Shifting from medical model to recovery model, continuum of care – CSU and Respite Center. Accountability/MHSA framework for services. Prevention – catching issues early. Improved communication, shift from individual problem to community solution. Enhanced reputation with the State. Can leverage other funding and program.
c) Increased care giver support (bereavement days for loss of a client or wellness built into H.R.). Prevention and wellness focus for all consumers and staff. Silo-busting (more collaboration). Continuing to reduce stigma and discrimination. Inpatient psych hospital in our County – complete the continuum of care, crisis residential, and child inpatient and child crisis residential. More resources for children.

Minutes by Annette LeFrancois, Administrative Assistant with the Health and Human Services Agency.