MENTAL HEALTH SERVICES ACT (Proposition 63)
FOCUS GROUP MEETING #3 NOTES
Olympia Glade Community Room, Grass Valley
August 10, 2005 (5:00 p.m. to 7:00 p.m.)

ADULTS

In attendance were Barbara Lindsay-Burns, Rod Pence, Jerry Petty, Laurie Burnett, Karen Angeloff, Digger Daniels, Cathy Lewis, Warren Daniels, Don Ryan, Bill Wilcock, Will Jodojn, Lily Marie, Joanne Norton, Dolores Jordan, Guy Kerr, Peggy Hobbs, Janice O'Brien, Custis Haynes, and Bruce Frazier.

In discussion, the following priorities were identified:

- Dual diagnosis - alcohol and drug treatment.
- People who present themselves to mental health need to be seen that day instead of waiting two weeks.
- Integrated services for co-occurring disorder. Create bridge through additional Behavioral Health employee specifically assigned to act as liaison between CORR and Behavioral Health.
- Staff and van ready to go out to (1) support parent or others in stress when their loved one is acting out, and (2) check on clients who are not seen and support their family members.
- Follow-up telephone support to consumers.
- Drop-in center.
- Expand community education.
- Detox center.
- Start with services for people.
- Free, donated, or low-rent building.
- Interdisciplinary team. Listen to the people being served. Psychiatrist who is also a consumer. Pie needs to be more evenly divided between professional and peer driven services.
- ACT wrap around.
- Growth and expansion of Spirit staff and services.
- Cross training of Spirit staff and staff from other organizations.
- Create “interdependency” between all organizations.
- Training 1-2 times a year for mental health professionals to learn more about co-occurring disorders.
- CORR and Spirit do a collaborative training on dual diagnosis.
- A goal of Hospitality House is to contract/interrelate all services. Hook under served up with all services.

Following the above discussion, baseline priorities were established. They are:

- Look at services for people first and build on that.
- Spirit considered as one way to support “people services” as part of wrap around services. Support both CORR and Spirit Center.
- Highly trained professional team as hub that would case manage individuals that presented for services.
- Client has a team (rather than the team has a client). Team has highly skilled members. Areas of expertise. 10:1 ratio. Begin, prove it will save money, have more and more teams. Transformation process.
- Remember that peers are “highly-trained professionals”.
- Consumer-driven model. Peers are equals for consumers.
MENTAL HEALTH SERVICES ACT (Proposition 63)
FOCUS GROUP MEETING NOTES #4
Olympia Village, Grass Valley
August 15, 2005

SENIORS


Group members continued working on prioritizing the needs of seniors for the Senior Focus Group proposal to be submitted to the MHSA Steering Committee. High priority areas included:

- Dementia and mental health
- Grief
- Respite

Victoria Johnston included in the draft proposal (1) input from group members and (2) information from the July 25 Senior Focus Group meeting notes. The draft proposal will be emailed to Focus Group members for their approval.

Members of the Steering Committee will be (1) Mary Tucker, and (2) Don Ryan. Victoria has someone who may be interested in being a Steering Committee alternate.
Truckee Focus Group
Written Proposal

Over the last few months, a group of Truckee service providers and residents have met to identify and prioritize the most pressing mental health needs for Truckee. After much discussion, we determined that the most critical need is to create a comprehensive system of support so people are able to access and fully utilize the existing mental health system. In our conversations, it became apparent that many people are falling through the cracks of the current mental health system in Truckee. We would like to enhance this system so people know where to access services and are supported in a nurturing environment.

Our proposal is called the Truckee Mental Health System of Support. The goal is to improve the quality of and access to comprehensive and coordinated mental health services by creating a culturally and linguistically competent mental health support system.

It involves a four pronged approach:

1) Increase the hours of the Nevada County Psychiatrist by 1 day a week
   We would like to address an immediate need in the mental health system by increasing the hours of the Nevada County (Truckee) Psychiatrist to 2 days a week. Currently, the Nevada County Truckee Psychiatrist is only available one day a week. We feel that many people are not being served and would benefit from an additional day a week. We would like to expand the hours of this position to increase the number of patients Nevada County is able to treat.

2) Increase the hours of Wellspring's Bilingual/Bicultural Counseling Support Services
   In order to support people receiving County Mental Health Services, there needs to be a support network in place that will help them sustain their health and wellness. Often times, a person receives Mental Health Treatment and then is left on their own before they may have achieved sustainable healthy behaviors. We would like to build up Wellspring Counseling Center’s support program so there is a safety net for people as they utilize and exit the County Mental Health System.

   We also understand the importance of creating a support system that is accessible by both our English and Spanish speaking residents. Currently, there are minimal mental health services available for Spanish speaking residents. Our top priority is to create a support system that is both linguistically and culturally accessible to all.

   We would like to increase the hours of the current Bilingual/Bicultural Therapist to 3 days/week. The current therapist is working in a very limited capacity and does not have a consistent position at Wellspring. We would like to commit funding to this position so both English and Spanish speaking people have access to affordable counseling services. In addition, we would like support a Bilingual Peer Counselor who would primarily be working with the Latino community to provide more informal support services. Initially, it would be a very part-time position at just a day a week. We plan to see what kind of
response we get from the Latino community and then build on the position as the need arises.

3) **Hire a Mental Health Advocate**
   To ensure that people do not fall through the cracks of the mental health system, we identified the need for someone to help navigate them through the system. For many people, accessing and qualifying for services can be a very daunting process. Many times, people give up before they even make it to the door. We would like to create a Mental Health Advocate position to help link and support people in accessing and utilizing the mental health system. They will serve as a contact point for people wanting to get mental health services. They will also be the connector between the Nevada County and Wellspring Counseling Center. Our hope is that this person will help bridge the services and actually create a system instead of individual services.

4) **Create a Peer Support Program**
   The last prong of this approach is to empower those who have received mental health services to be in a role where they can be a support for others. We would like to create a Peer Support Program where volunteers are trained to become peer counselors. This program would be initially be coordinated by the Mental Health Advocate and then essentially run by volunteers. We plan to research best practices and adopt a model similar to that of the Spirit Center in Grass Valley. We feel this is the most effective way in shifting the power dynamic in the mental health system and tapping into the wisdom and knowledge of people who have actually used the system.

*Please see attached budget.*

We are very excited about this opportunity to make such a large impact on the underserved mental health community in Truckee. We thank you for considering our request and look forward to hearing how this might fit into a county wide plan.
## Truckee MHSA Budget

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Amended on 9/2/2005

255

draft 8.16.04
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Amended on 9/2/2005

256

draft 8.16.04
MENTAL HEALTH SERVICES ACT (Proposition 63)
TRUCKEE FOCUS GROUP MEETING NOTES #2
Joseph Center, Truckee, CA
August 10, 2005 (9:00 a.m. to 12:00 p.m.)

In attendance were Kim Bradley, Robin Gauldin, Ron Fischer, Mary Folck and Chris Carter.

In discussion, the following priorities were identified:

- Advocate/Coordinator (bilingual): Full time. For family advocacy, outreach to schools and other places like hospitals and law enforcement. Provide training and education. Identify and coordinate peers. Requires BS in psychology or graduate degree in psychology and front-line experience. Master's degree ($25-$30 per hour). Wellspring to be the employer.
- Peer Support Program – Intervention through peer counseling. Train peers to do counseling. (Become aware of what already is developed in order to not recreate what already exists.) Use local trainers (volunteers already trained by Tahoe Women Services). Tie in and build in support groups. Support groups could include (1) teen parents, (2) parents of teens, (3) parents, and (4) consumers.
- Access to a board certified child and adolescent psychiatrist. Prefer bilingual and bicultural. For medications. Work closely with therapist.
- Bilingual and bicultural therapist. Could be employed by Wellspring. Work closely with psychiatrist.
- Training for law enforcement and teachers (could fall under advocacy).
- Bilingual support.

Kim Bradley will write a Truckee Focus Group proposal for the MHSA Steering Committee.

If the MHSA Steering Committee meetings can be changed from Tuesday evenings, Ron Fischer will be a Steering Committee member. Mary Folck will be a consumer member of the Steering Committee. Chris Carter from Tahoe Women Center is interested in being a provider member of the Steering Committee if her school schedule will not interfere. Susie Coyote was also suggested as a Steering Committee member. Research will be done on setting up a videoconference so Truckee residents will not have to commute to Nevada City for each meeting.
San Juan Ridge Behavioral Health Collaborative

Grant Request for Proposition 63 Funds
San Juan Ridge Behavioral Health Collaborative
September 1st, 2005

The San Juan Ridge Behavioral Health Collaborative (SJRBC) is a group of local residents, educators, therapists, and the management team of Sierra Family Medical Clinic (SFMC) who are trying to improve access to mental health services in the surrounding community.

The Collaborative Proposes:

A. Retaining the services of a Behavioral Health Services Coordinator:
This would be a 3-day a week position for an individual to coordinate behavioral health and expanded social services access locally. SJRBC would create a selection process for this position. Ideally, this individual would be a local resident and would be engaged as an independent contractor. Oversight by the SJRBC would occur at monthly meetings where the Service Coordinator would report.

The Coordinator would:
- Organize and administrate the San Juan Ridge Support Center (explained below).
- Improve access to county services by acting as a liaison between the county and local residents:
  a) Work with the County Mental Health Department to ensure that appropriate local residents are evaluated in a timely fashion and continue with ongoing treatment.
  b) Special emphasis would be placed on improving sheriff’s services and response times (particularly around mental health related issues of violent mentally disturbed individuals and drug abuse).
  c) Set up a reference center of available services both at a county and local level and assist residents in finding the appropriate source for services.
  d) Improve resources available to special needs groups locally including such populations as teens, children, and veterans.
- Family Medical Clinic, which has a full time therapist and a consulting psychiatrist on site.
- Develop local fundraising to expand and support ongoing operations.
- Improve awareness in the local population of the symptoms and risks of mental health disorders and drug abuse.
- Encourage universal screening for mental health disorders at both Sierra Family Medical Clinic and at local Support Center with prompt referral options for those testing positive.
- Ensure compliance with HIPAA standards in all SJRBC activities locally.
- Collect and track basic demographic and diagnosis information for each patient to assist in future grant requests
- Train and oversee all volunteers who participate in SJRBC activities.
B. Opening a San Juan Ridge Support Center:
This would be a community center opened to address the mental health and related social needs of local population. It would be located centrally, near North San Juan or at a local school offering a free space. It would be open at specific times on at least three days of each week.

It would provide:
- A safe, friendly, non-clinical environment for residents to seek information and services.
- A place for local mental health and drug abstinence support groups to meet regularly.
- A place for classes on relevant mental health issues such as parenting skills and behavior change.
- Resource information for mental health services and referrals both locally and at a county level.
- Free screening for mental health disorders.
- Access to information about Sheriff's assistance for mental health or drug related problems.
- An easy place to contact the Services Coordinator for assistance.

C. Providing Funds for mental health services to area residents:
This psychotherapy would be provided by licensed local therapists, which the Service Coordinator has identified, who wish to participate in this referral system. (These funds would not be used to cover any visits at SFMC, which has separate funding.)

This funding would allow for:
- A sliding scale fee structure (see attached) so that qualified individuals or families (Patient Demonstration of Income attached) would pay a maximum of only $25 for each visit with those in the most indigent tier paying nothing.
- The engagement of Private therapists who would receive $50 an hour for therapy and this amount would be apportioned between grant funds and the individual’s co-pay based on the sliding scale. Local private therapists would submit an invoice monthly to the Services Coordinator and be paid within 30 days. Co-payments due from individuals would be the responsibility of the therapist to collect.
- Behavioral Health Classes taught locally at the request of the Service Coordinator by Therapists who would receive $50 per hour for this service.

The following conditions would apply:
- Those with alternate coverage already available would not be eligible.
- Therapy will be limited to 5 sessions yearly for individual therapy and for 6 sessions for family therapy.
- A geographic service area of “local residents” will be defined to determine eligibility.
- Residents must choose from the approved list of local therapy providers.
San Juan Ridge Behavioral Health Collaborative

Funds Requested:

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<td>Outreach Materials</td>
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<td>Additional professional consultation services</td>
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<td>Rent for Support Center @ $500 per month</td>
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<td>Utilities and Telephone for Support Center @ $500 per month</td>
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<td>Set-up costs (furniture, phones, computer, etc.)</td>
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<td>250 Therapy Sessions for qualified individuals</td>
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<td><strong>Total Funding Requested</strong></td>
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Should funding be granted for this proposal the SJRBHC would form a legally constituted not for profit 501 (c) 3 corporation and comply with all pertinent licensing and governmental regulations.
San Juan Ridge Behavioral Health Collaborative

INCOME ELIGIBILITY GUIDELINES - 2005

100% of Federal Poverty Level

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150% of Federal Poverty Level

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RURAL HEALTH SERVICES ELIGIBILITY FORM

Do not give to Medi-Cal, Medicare or other insurance patients. A separate form must be completed for each patient for each visit.

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1. Is the patient: 
   a. On Medi-Cal now?  
   b. In a prepaid Health Plan (for example Kaiser)?  
   c. On other insurance of any kind?

2. How many people are in your family?

3. How much money does your family make before taxes? $________ or $________ Monthly or Yearly

4. Major source of family income:
   a. Professional/Technical
   b. Labor/Production
   c. Agriculture
   d. Services/Sales
   e. Unemployment
   f. Retirement
   g. Disability
   h. Public Assistance
   i. Other income
   j. None

I certify under penalty of law that the above information is correct.

Signature of Parent/Guardian or Patient if over 19 __________________________ Date __________

Relationship to Patient

Referral for Eligibility Assessment (Office use only)

☐ Healthy Families  
☐ Medical  
☐ CMSF
MENTAL HEALTH SERVICES ACT

COMMUNITY MEETING, SAN JUAN RIDGE, 8-2-05

IN ATTENDANCE: DeOnne Noel, Diana Pasquini, Peter Van Houten, Wilbur R. Welkes, Geeta Dardick, Sam Dardick, Arlo Acton, Robyn Martin, Charlene Welker, and Jim.

SUMMARY:
San Juan Ridge is a community with unique mental health issues created in part by the geography of the area; it is remote from the population center of Western Nevada County, and it borders on two other counties. Because of its remoteness from Nevada City-Grass Valley, the Ridge suffers from a lack of timely presence of law enforcement and crisis intervention, and a lack of services available in the community itself. Because of the border with Yuba and Sierra County, residents of those counties congregate on the Ridge and sometimes need services from Nevada County.

Residents of the Ridge recognize the need for a central service center that is comfortable and accessible to its variety of residents, including the unserved and underserved, the homeless, and those dealing with methamphetamine and other drug use. A satellite center could provide education and early intervention services, including parent support classes for both children and parents.

Residents of The Ridge are developing a plan to work with the Sierra Family Medical Center, located on Tyler Foote Road. That center is agreeable to expanding its counseling and mental health services, particularly to the underserved. It has and uses telepsychiatry equipment, now has a psychiatrist on staff two days a month, and has a counselor available. SFMC agrees with the concept of providing counseling at locations accessible to other populations on The Ridge.

Residents of The Ridge want an effective advocate-outreach program to provide education, referral, and early intervention before a situation escalates to a crisis.

NOTES:
1. Severity of the problem. The Ridge gets left out, always.
2. Three-county position: Other county problems come to The Ridge. Strange alliances at the edge.
   People come to The Ridge from Marysville, to the parks and the river.
3. No police presence. In a boiling pot of social issues. Deputies do NOT use fire station substation.
4. Need a mental health outstation or satellite office, with a counselor available at least once a week.
   Where? School, library...SFMC.
5. Prevention and education.
6. Personal and professional contact.
7. SFMC now has a psychiatrist two days a month (Eric Rubenstein) and a counselor.
8. Parenting classes and followup.
10. Outreach is different in this community.
11. Health Dept. RV?
12. What is available? Need resource information, centralized, updated, available.
13. Have a phone tree of people who care.
14. A referral information system is being worked on within the county (Sam Dardick). The schools have an information system (ask Terry McAtee). MHSA (Prop 63) will soon have a computer information system available for input of local info. (Joan B.).
15. Need an effective crisis response system.
16. North San Juan is a village; San Juan Ridge is the community.
17. Need services for dual diagnosis, the meth problem is growing quickly. There are some peer dual diagnosis services at the AIC building – AA and NA meetings.
Proposal for Services for the Mental Health Services Act
(Proposition 63) for Latino Families in Western Nevada County

Latino families in Western Nevada County report that they experience isolation, depression at times (post-partum and clinical), and symptoms of post-traumatic stress syndrome. Alcoholism and emotional domestic violence (at times also physical violence) occur frequently. Parents often use spanking as a form of discipline, saying “that is how they do it in Mexico” (personal report).

Western Nevada County provides very limited resources for counseling for the Latino Community. The need for counseling services in Spanish is documented in the requests for counseling at Sierra Nevada Children’s Services, in the Family Needs Assessments of Placer Community Action Council/Head Start Family Advocates, from a Family Advocate at the Nevada County Infant Program, and through the collaboration with the Maternal/Child Health program at the Nevada County Health Department. At this time, Nevada County Behavioral Health has one part-time, bi-lingual, contracted Marriage/Family Therapist. Due to lack of documentation, many families do not qualify for direct Nevada County Behavioral Health services. In order to qualify for services at NCBH, Latino families need to have Medical &/or Healthy Families. Currently, no funded program of direct counseling services from a licensed therapist for non-Medical clients exists in Western Nevada County.
We, the collaborative of Colaborando en Espanol, a local group of agencies that has been in existence since March of 2004, look at "mental health services" in a broad context that includes: pre- and peri-natal education and support through the services of Registered nurses, Family Advocates and Promotoras, Early education in the Head Start model (including parenting, child development) for birth to age 3 children and their parents, Early Intervention for children with special needs, early assessment and intervention for children with behavioral problems, and education about family dynamics and communication for families with older children. These services would be in addition to traditional mental health services for depression, PTSD, DVC, etc. To this end, we propose the following:

**Plan for Mental Health Services for Latino families in Western Nevada County**

1. Funding for monthly 2 hour interagency referral and case management sessions by local Promotoras, Family Advocates, Registered Nurses and Marriage/Family Therapist.

2. Funding for Coordinator of Colaborando en Espanol for program management, minutes recording, agenda formation and general coordination.

3. Funding for increased hours for the Home Visitors, Promotoras, Family Advocates within the guidelines of Proposition 63.

4. Funding for 6 hours/week for Marriage/Family therapist for private sessions
at Team III Counseling Center &/or on Home Visits.

5. Funding for rental of space at Team III Counseling.

Budget for Prop 63 Services for Latino Families in Western Nevada County

1. 8 hours/month for Coordinator of Colaborando en Espanol
   @ $25.00/hr, for coordination, agenda, minutes etc. $2,400

2. 56 hours/week for Home Visits by Home Visitors, Promotoras, Family
   Advocates @ $15.00/hour including case management (50 weeks)
   $42,000

3. 4 hours minimum/6 hours maximum for Marriage/Family Therapist
   @ $25.00/hr on Home Visits &/or at Team III (50 weeks)
   $5,000-
   $7,500

4. Peer counseling program-training and coordination
   $?

5. 4-6 hours/week rental at Team III Counseling Center @
   $12/hour (50 weeks)
   $2,400-
   $3,600

$51,800-
$55,500
From: Tanya Rentz <tanyadr2001@yahoo.com>  
To: laura@cofnr.org, nohemiH@sbglobal.net, Joan.Buffington@co.nevada.ca.us, liz_viciana@worldiz.net, fa6@pcac-in.org, avila@internet49.com, cristin2002@yahoo.com, ariel@snco.org, jody@dvsec.org, sburns@gvsd.k12.ca.us, phanson@nuhsd.k12.ca.us, Jean Soliz <jean@first5nevco.org>, csi@sysmatrix.net, christine.garner@co.nevada.ca.us, mary.graebner@co.nevada.ca.us  
Date: 8/1/2005 3:34:00 PM  
Subject: (possible spam: 11.9757) Minutes of Colaborando en Espanol 7-5-005

Colaborando en Espanol [here are the minutes] of 7-5-05, also of 6-14-05. Next meeting Tuesday, Aug. 2, 2005, 2:00 pm, Silver Springs Head Start, See you there!  
Tanya  

Present:  

*Reviewed the minutes of the meeting of June 14, 2005.

*Joan gave a presentation of Prop. 63, the Mental Health Services Act. She passed out copies of the Questionnaire that the Prop. 63 Steering Committee put together, in Spanish and in English, then we brainstormed ideas for a proposal for the Latino community for next year.

*In summary (Joan also sent out notes which I will attach):
-The Latino community needs Home Visitors who can do resource and referral, initial assessments for social services and referrals needed, needs assessments.
-We already have the Promotora program, as well as Family Advocates/Home Visitors at Foothills Healthy Babies and the Nevada County Infant program.
-We would like an expansion of these programs within the guidelines of Prop. 63. A problem exists, however, because Prop. 63 cannot fund something that is already being funded—??!!
-The Latino community needs a licensed therapist at a given location one day/week where the Promotoras/Family Advocates can schedule families in, (like the dental program)—possible locations could be

267
Team 3, Spirit Mental
Health Peer Empowerment Center, Eskaton, Churches
(Hospitality House model),
Hennessey School, Union Hill.
- We have to have a proposal by Sept. 1 to give to the
Prop. 63 Steering Committee.

*Sept. 16, 2005-Día de Independencia Fiesta—Irma said
Avila was going to talk to Marie's restaurant @
coordinating efforts, although there was some feeling
that we have different agendas. Nohemi will also
inquire @ having the Fiesta at Hennessey School.

*Summer Preschool Program-the program is closed to new
families as of now.

*PCAC/Head Start recruiting—we ran out of time because
of the Prop. 63 discussion—check in next time.

Date for next meeting: Tuesday, Aug. 2, 2005 2:00 pm,
Silver Springs Head Start office.

Respectfully submitted: Tanya Rentz

Minutes of Colaborando en Espanol, June 14, 2005:

Present: Irma Calderon, PCAC/Head Start, Avila
Lowrance, Nevada County Infant Program, Tanya Rentz,
MFT, Spanish Counseling Services, First 5 Commission.

1. Discussed summer picnic, plan for Sept. 16, 2005,
Mexican Independence Day—talk to Marie (from Marie's
Restaurant) @ coordinating with her, so that we don't
have conflicting events.
2. Summer School Program: there is a Summer School
Program for Latino families, at Lyman Gilmore School,
from 6-8 pm, Wednesday evenings. Leyda Morales is
doing a program for the parents, and Marina
Bernheimer, Irma Calderon, and Avila Lowrance are
doing a program for children 3-5 years old. It begins
June 22, 2005, and runs for 10 weeks, with songs,
stories and school
readiness.
3. Finances for 5 de Mayo celebration—figure them out
next time.
4. PCAC/Head Start is recruiting for next year—please
call Irma with names
and phone #s of families with children birth to 5.
5. A good daycare place is A Kid's Place, near
Brighton St., the owner is Caroline, and her husband
Date: August 23 2005

To: Mental Health Services Act Steering Committee

From: The Palm Tree Group-the focus group of the Unified Family Court

Nevada County Superior Court handles all cases that involve families and children under the philosophy of "One Family, One Judge." This known as a Unified Family Court. There are several distinct needs that have emerged from the Unified Family Court in response to Prop. 63, the Mental Health Services Act. The following proposal attempts to meet the most urgent needs of children and families in Unified Family Court.

Proposal Part A:

1. Family Court

Every day parents come to Family Court asking the Court to protect them and their children from the other parent by issuing restraining orders. Reasons stated:

1) Incidents of domestic violence;
2) Drug and alcohol abuse,
3) Child abuse and neglect;
4) A recent arrest or incarceration,
5) Mental illness.

Mental illness is often the primary cause of family violence and substance abuse, but the matter comes to court under another name.

Requests for protection initially come to court in the form of allegations. The court cannot make a finding based solely on allegations by one parent against the other. Assessments are available at reasonable costs for reasons 1,2 and 3 and these often bring to the surface mental health issues. There are no low cost assessments for allegations of mental illness.

The Court and the family need a psychiatric or psychological assessment to clarify the allegations and to screen for mental health issues. This could help get to the underlying problems sooner rather than later, and save the family from a prolonged state of uncertainty and anxiety. The assessment would give the Court a roadmap on how to serve the needs of the family.

When parents come to Court seeking protection from the other parent, it is clear that the family is in crisis with both parents and children in great emotional distress, often to the point of being traumatized. Without an intervention, these problems can turn out to be permanent and lead to an adjustment disorder or a post-traumatic stress disorder.

Intervention:

Families come to Court seeking protection. Crisis intervention at this early stage would reduce anxiety, help stabilize the person and facilitate a rapid assessment of what additional services are needed. An immediate intervention would focus on processing or debriefing the incident or experience from an emotional and psychological perspective, leaving the legal aspects of the case to the Court.
Supervised Visitation:

When there are unresolved mental health concerns, the children are impacted by a parenting plan that limits or even precludes visitation with the parent in question. If the situation persists, there is a tendency for the parent with alleged mental illness to disengage over time due to feelings of guilt and shame from being stigmatized as needing supervision when they are with their children. These children are deprived of frequent and continuing contact with a parent. In some cases, the state of uncertainty sows the seeds of alienation between the parent in question and child. In some cases, it sows the seeds of resentment and rebellion between the child and the custodial parent.

Our proposal requests funds to be used to pay for supervised visitation. Most parents that cannot afford a mental health assessment cannot afford to pay for supervised visitation.

Currently in Nevada County, there is only one professional provider of supervised visitation. That person is only available in the evening and on weekends. With such limited resources, parents often look to family and friends to provide supervision.

2. Juvenile Court

Many children who commit crimes and are detained in Juvenile Hall have emotional or psychological problems that are undiagnosed and therefore remain untreated. Untreated mental illness may lead a young person to engage in behaviors that are potentially a danger to self or others. Out of distress and confusion, the young person may become combative toward staff or destructive to property, which results in further sanctions, more resentment and frustration, turning to anger that erupts into more violence. Or the anger is internalized into depression, despair and feelings of hopelessness. Such a young person winds up in an endless downward spiral.

This downward emotional and behavioral spiral is precisely the dynamic that Adult Mental Health Courts are designed to address. We include a description of how that model works. It is known that defendants with mental health concerns, which motivate their criminal behavior, have high recidivism rates. The standard consequences of being convicted of crimes do not typically help these individuals learn more appropriate, legally conforming behavior patterns. This high recidivism rate/poor response to criminal conduct is mainly due to untreated mental illness motivators. Defendants with mental illness manifest positive benefits from Mental Health Court services. They receive psychopharmacological and counseling support and their criminal recidivism rates drop. A financial benefit is realized in those jurisdictions with Mental Health Court services for adults because of reduced criminal recidivism. Therefore, the costs typically associated with reprocessing the same defendants on repeat criminal charges are reduced. In addition, these individuals receive the treatment and support they need.

Adolescents would realize the same potential benefit if funding were available to provide psychological assessments in the Juvenile Court. So many times, profound negative implications exist for a troubled adolescent when their underlying mental illness remains undiagnosed and untreated.

Models of juvenile delinquency development outline the possible factors associated with the "antisocial behavior" often observed in teens. These include:

- untreated mental illness,
- various problems in the families of these troubled teens,
- problematic peer influences, substance abuse problems,
- previous trauma histories resulting from child maltreatment and neglect.
Trauma related disturbances could be quite complex involving a variety of symptoms and troubling behaviors. These symptoms and behaviors are often interpreted as a personality disorder, such as borderline personality disorder. Without knowing that the behavior is trauma related the young person might be labeled as difficult, dysfunctional or antisocial.

Of these factors, it is commonly found that notable mood disorders, Attention Deficit Hyperactivity Disorder (ADHD), and learning disabilities are co-morbid with the delinquent behavior. If left undiagnosed and untreated, there is little likelihood that the adolescent will be able to learn new, more productive behavior patterns. When properly treated with medication and counseling services, the chances of helping a young person develop more potential that is positive for their future increases dramatically. Properly diagnosing and treating the mental illness concerns in adolescent clients of the Juvenile Court will (hopefully) decrease the likelihood these teens will end up in the adult Criminal Courts, an outcome that is all too often observed with untreated adolescent mental illness.

Carol May, Superintendent of Juvenile Hall, stated, "Many mentally ill minors arrive at Juvenile Hall that have been living on the streets, self medicating on illegal substances. When they are booked, even after an ER clearance, their behaviors cannot be correctly diagnosed until these substances completely leave their system. We have witnessed excessive crying, incongruent or flat affect and erratic thinking. Some of these offenders are self mutilators whose emotions start to come unraveled, they are unable to bear or understand the pain they are in and they are unable to voice what they think is wrong with them- they just don't feel normal. For staff it is difficult to determine if an offender is conduct disordered or suffering from an undiagnosed mental illness as their extreme disruptive behaviors create constant chaos in the facility".

As indicated above the mental health status of a young offender cannot be diagnosed correctly until whatever self-medicating drugs they are using have left their system, however, a psychologist evaluates less than 20% of the minors. That means that over 80% are not evaluated, and therefore go untreated while they are in custody. This is a lost opportunity to make a difference. If a minor has a therapist that wants to come to the Hall to continue therapy with their client they are welcome to do so. The percentage of minors who receive treatment in this way is extremely low. REACH Counseling works with 4 or 5 minors who are under a placement order. The Juvenile Hall reports that less than 25% of the detained minors receive mental health services.

3. Interrelationship between schools and the courts

Children under the age of 18 must be provided with an appropriate public school education. Children torn apart emotionally during a contentious divorce begin to fail in school due to behavioral issues, lack of interest, and the prevailing chaos. All too often, a good student becomes a failing student and no one in the family has the time or interest in addressing the child’s education, or they have the time and interest, but are sadly limited by mental health issues. The child’s school needs to be knowledgeable about what is happening in the family.

Young people who are housed in Juvenile Hall need to be involved in education, or they will continue the spiral toward disaster. Connections and follow-through between courts, and schools needs to be solidified.

Sharing of information and dialogue between schools, Family Court, Juvenile Court and Juvenile Hall regarding the student records, history of special education or leaning difficulties, school attendance records, family issues is necessary.
Case management enabling a stronger connectivity between incarcerated youth and the public schools could address these issues.

**Part B: Therapeutic Treatment**

In addition to the need for assessment, there is a need for treatment. The proposal calls for a pool of money to contract for services to treat parents and children who come to Family Court with mental health issues. This program will be designed to help parents be the caring and effective parents that they want to be and that their children need. It will also help the children who struggle due to their parent’s mental illness, or their own struggles with mental illness and depression.

It also calls for therapeutic intervention and treatment for children who come through Delinquency Court. Many of these children are in crisis. Sometimes they are detained after a family blow-up. Often they are depressed and self-medicating and engage in destructive activity such as self-mutilation or prostitution. A therapist who can promptly attend to the child’s need for intervention, assessment and treatment will provide a great service to the child, the family and the community.

This is a proposal for:

A. **Family Services Coordinator** (professionally licensed and trained) who will address the issues stated above by providing the following services:

1. Evaluate family court participants for mental health issues
2. Oversee supervised visitation which is ordered by the court
3. Assess detainees in Juvenile Hall, determine their mental health history, arrange for and monitor medications. Provide staff with input regarding the behavior
4. Case manage the education needs of children in Family Court and in Juvenile Court by reviewing school records, communicating with the local school district staff regarding the students’ educational history.
5. In any group decision process regarding children, include school district staff in the educational component.

B. **Family Services Therapist** who will provide the following:

1. Crisis intervention
2. Treatment for families and children in Family Court
3. Treatment for minors detained at Juvenile Hall

The estimated annual cost for this proposal for the Unified Family Court is $184,000. These costs would include professional time, supplies, support staff, and supervised visitation. A work plan and job description will be developed that meets the needs of children and families involved with the judicial system.

**Closing Statement**

The Palm Tree Group is a group of people who represent a broad cross section of the community. They believe that county agencies and non-profits and schools can, by working together, make things better for children and families.

We realize that other groups have companion proposals, which we also support. A family resource center would be a great benefit to our community. We also recognize that the provision of evaluation
and treatment of adults needs to be addressed. There are many areas that need the community’s attention.

Our two-part proposal addresses concrete needs that will help members of our community in the greatest need. Given the unmet mental health needs of the children and parents with whom the Court deals, we can conceive of no better use for Prop. 63 funds.

Thank you for considering our proposal.
List of members of the Mental Health Services Act (Proposition 63) Focus Group present at the August 22, 2005 noon meeting at the Courthouse.

1. Robert Erickson- Nevada County Behavior Health (530) 265-7168
   Email: Robert.Erickson@co.nevada.ca.us

2. Carol Fuller-Powell- Charis Youth Center (530) 477-9800
   Email: Carolp@charisyouthcenter.org

3. KC West- Domus (310) 657-2935
   Email- kcwest@domussystems.com

4. Diana Ely- Nevada County Superintendent of Schools (530) 478-6400 x221
   Email: diana@nevco.k12.ca.us

5. Rachel Pena- Nevada County Child Protective Services (530) 265-1655
   Email: penar@cws.state.ca.us

6. Bonnie Taylor- Nevada County CASA (530) 265-9550
   Email: bunnie@casofnc.org

7. Dave Scinto- Domestic Violence & Sexual Assault Coalition (530) 273-3200
   Email: Dave@dvsac.org

8. Jody Anderson- Domestic Violence & Sexual Assault Coalition (530) 272-2046
   Email: Jody@dvsac.org

9. Mary Folck- NAMI (530) 587-3860
   Email: maryfolck@hotmail.com

10. Doug Bond- Nevada County Behavior Health (530) 470-2403
    Email: Doug.Bond@co.nevada.ca.us

11. Jeff Brown- Nevada County Behavior Health (530) 470-2562
    Email: Jeffrey.Brown@co.nevada.ca.us

12. Lael Walz- NAMI (530) 265-2689
    Email: jdwlaw@mcon.net

13. Carol May Carl F. Bryan, II Juvenile Hall/Probation (530) 265-2601
    Email: Carol.May@co.nevada.ca.us

14. Karl Snyder- Nevada County Behavior Health (530) 265-1763
    Email: Karl.Snyder@co.nevada.ca.us
15. Serge Aronow- Nevada County Superior Court (530) 265-1476
   Email: Serge.Aronow@nevadacountycourts.com

16. Gretchen Serrato- Nevada County Superior Court (530) 470-2567
    Email: Gretchen.Serrato@nevadacountycourts.com

17. Sean Metroka- Nevada County Superior Court (530) 265-1313
    Email: Sean.Metroka@nevadacountycourts.com

18. April Bullock- Nevada County Superior Court (530) 470-2519
    Email: April.Bullock@nevadacountycourts.com

19. Julie McManus- Nevada County, County Counsel (530) 265-1319
    Email: Julie.McManus@co.nevada.ca.us

20. Chuck Coover- Nevada County CASA (530) 346-8775
    Email: Chuck@Coover.net
MENTAL HEALTH SERVICES ACT (Proposition 63)
FOCUS GROUP MEETING NOTES #3
Nevada City Courthouse, Nevada City
August 22, 2005 (12:00-1:30 p.m.)

PALM TREE

Participants included Lael Walz, Carol May, Karl Snyder, Serge Aronow, Gretchen Serrata, Sean Metroka, April Bullock, Julie McManus, Chuck Coover, Jeff Brown, Robert Erickson, Carol Fuller Powell, K.C. West, Diana Ely, Rachel Pena, Bonnie Taylor, Dave Scinto, Jody Anderson, Mary Folck, and Doug Bond.

The draft proposal for the MHSA Steering Committee was reviewed. It included an individual who would be hired to assess parents, to assess kids in Juvenile Hall, and to work with families and children around delinquency, education, and health issues.

The following input was given:

- Family Court parents are asking for protection for their children. Involve mental illness issues. A contracted person on staff could assess emergency cases that come in. The risk to children could be assessed.
- Assess children in Juvenile Hall to make a difference to that young person, their family, and the community.
- Juvenile Hall needs support of a therapist. Coordinate therapy and treatment during time in the hall and support transition out of the hall. Some intervention could be done following assessment.
- Add a unified family court therapist. Have coordinator and therapist working together.
- Have pot of money for kids that don’t qualify for Behavioral Health support services and whose parents are unable to afford to pay for therapy for their kids.
- Have goal of family support team. (Not enough money to do it all now.)
- Crisis intervention in Family Court where people are decomposing emotionally. Trauma and breakdown of the family is occurring. Expand to crisis intervention during assessment process. Include relationship with schools.
- Pool of money for therapy rather than employing an individual. Ongoing therapy can be contracted based on what kind of therapist would be most appropriate and where the kid lives, etc.
Nevada County Forensic Task Force on Mental Illness

The Nevada County Forensic Task Force on Mental Illness recommends that the County’s Mental Health Services Act proposal include the following:

1. Establish an Assertive Community Treatment program (ACT) for adults.
2. Establish a Children’s System of Care wraparound program.
3. Establish a mobile crisis intervention program utilizing mental health clinicians to accompany law enforcement officers.
4. Provide clinical services to incarcerated adults and juveniles with psychiatric illnesses. Services are to include monitoring medical treatment, providing psychotherapeutic treatment and disease education. Clinicians are to have the authority to hospitalize a person undergoing a psychiatric emergency.
5. For Mental Health Court clients, provide intensive case management and psychotherapeutic services, including integrated treatment for those with co-occurring mental illness and addictive disorders.
6. Recognizing that capital improvement monies will eventually be incorporated into local MHSA funding proposals, the Task Force also recommends that a crisis facility be developed when that funding is available.

BACKGROUND

In August 1999, the Board of Supervisors affirmatively responded to a request from NAMI “to establish an improved system of care for forensic mentally ill adults in Nevada County and to avoid the criminalization of individuals with neurobiological brain disorders, commonly known as mental illness.” The Board directed staff to create the County Forensic Task Force on Mental Illness, and it has met monthly for the past 6 years. Each year the Task Force determines its goals and objectives. This year’s Objective 7 is to provide input to Behavioral Health regarding Mental Health Services Act proposal.

The Task Force includes Judge John Darlington as judicial liaison; District Attorney Michael Ferguson; Public Defender Thomas Anderson; Chief Probation Officer Doug Carver; Juvenile Hall Superintendent Carol May; April Bullock, Director of Alternative Court Programs; Julie McManus, Deputy County Counsel; Sheriff Keith Royal; Lt. Mike Hughes, Sheriff’s Department; Chief Lou Travato, Nevada City Police; Chief Scott Berry, Truckee Police; Chief John Foster, Grass Valley Police; George McKnight, California Forensic Medical Group (CFMG); Behavioral Health Department Director Robert Erickson and several departmental staff; and community representatives including Joan Toensing, Mental Health Board; Rod Pence and Lael Walz, NAMI; and Iden Rogers and Barbara Lindsay-Burns, SPIRIT.

277
Since its inception, the Task Force has discussed the need for improved services for persons with a serious mental illness who become involved in the justice system. Limited financial resources have not daunted the dedication of the Task Force to address the needs as feasible. The Task Force facilitated the establishment of the Mental Health Court, as an example, without external funding.

ANALYSIS

MHSA guidelines describe three types of program funding. Most significantly is “Full Service Partnership Funds — funds to provide ‘whatever it takes’ for initial populations.” The County is required to request the majority of its Community Supports and Services total funding to be in this category by FY 2007-8. An Assertive Community Treatment (ACT) program (also known as PACT—Program for Assertive Community Treatment) for adults and adolescents and a wraparound program in a Children’s System of Care would most appropriately address that issue.

ACT is an evidenced based, successful treatment program in which there is a maximum recipient to staff ratio of 10 to 1 and recipients receive a multidisciplinary, 24/7 service from a mobile team within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, addiction, peer support, and vocational rehabilitation. Targeted individuals would include those who are eligible regardless of their legal status. Assisted Outpatient Treatment (AOT) is court-ordered ACT and would help those who need that level of support.

Guidelines also describe “Outreach and Engagement Funding — funds for outreach and engagement of those populations that are currently receiving little or no service” where funds can be used “for clients and families to reach out to those that may be reluctant to enter the system.” Persons with a serious mental illness who may be hesitant to enter the front door of the treatment system may become involved in the criminal/juvenile justice system and may be suitable for ACT/AOT and wraparound services.

DMH also categorizes MHSA funding as “General System funds [that] are needed to help counties improve programs, services and supports for all clients and families (including initial Full Service Partnership populations and others) to change their service delivery systems and build transformational programs and services. ...Specific examples include mobile crisis teams....” Mobile crisis teams, linking law enforcement and mental health staff, would improve services to individuals experiencing a psychiatric emergency. This program has the potential of reducing the number of people experiencing a psychiatric emergency having to go to the Emergency Room at Sierra Nevada Memorial Hospital and Tahoe Forest Hospital in Truckee.

In Nevada County, an estimated 20% of adults in the jail and up to 30% of juveniles in juvenile hall have a serious mental illness. Although limited psychiatric medication management services are provided, the Task Force recommends additional treatment modalities, including clinical personnel who can monitor medical treatment, provide psychotherapeutic support, and disease education. The staff also need to have the authority to hospitalize a person undergoing a psychiatric emergency.
For Mental Health Court to better meet the needs of the clients, additional psychotherapeutic services and intensive case management services are recommended. Because clients commonly have a serious mental illness and an addiction disorder, staff must be able to provide integrated treatment services.

**CONCLUSION**

The Forensic Task Force on Mental Illness is a multi-agency collaborative that has worked for over five years to facilitate dialog to improve the treatment of and services for persons whose access to mental health care often come via the criminal justice system. The Task Force views the MHSA as a unique and unprecedented opportunity to more fully address the needs of this population. In conjunction with the proposal put forth by other focus groups, effective allocation of MHSA resources will result in a community that can respond to those in crisis, avoid criminalization of individuals with a mental illness, and provide integrated treatment services to those in the greatest need.
MENTAL HEALTH SERVICES ACT (Proposition 63)
FOCUS GROUP MEETING NOTES #2
Nevada City Courthouse, Nevada City
July 26, 2005 (12:00–1:30 p.m.)

JUDICIAL

Lael Walz opened the meeting at 12:05 p.m.

Meeting Participants

Judge Darlington, Carol May, Julie McManus, Iden Rogers, Barbara Lindsay-Burns, April Bullock, Mary Lowe, Tom Anderson, Rod Pence, Doug Bond, and Joan Buffington and Gail Gordon of MHSA.

Discussion took place related to identification of priorities for use of MHSA funding. This Judicial Focus Group (addressing the needs of adults) will have a voice for both Juvenile Hall and Wayne Brown Correctional Facility. Three priorities identified include (1) continuity of medical care, (2) therapeutic support (in addition to prescribing medication), and (3) continuity of care (transition plan) when people are released. Specific areas of need that were addressed are as follows:

Assessment and Treatment

- Need to identify individual needing service when they arrive at jail. Need to be proactive. Some who are arrested often are known before they hit booking desk. Need adequate assessment. After assessment, keep them safe and treat them. Find way to identify them before or soon after their arrival.
- Therapist do assessment and make contacts through Behavioral Health, etc.
- CMFG does physical assessment. Does not do mental health assessment.
- Therapist needs master's degree in order to assess. (Include CMFG in conversation regarding this position. This additional person will impact CMFG. Need to consider CMFG contract to be sure contract is not violated.)
- Share one clinical person between Juvenile Hall and Wayne Brown rather than using two lower-level people. Need someone with Master's Degree.
- Need therapist with the right qualifications – how much MHSA money will it require?
- Include co-occurring disorders in assessment and treatment at both Juvenile Hall and Wayne Brown. They overlap. Eighty to ninety percent have co-occurring disorder. ACT includes this.
Crisis Intervention

- Need counselor on site (at Juvenile Hall) to deal immediately with kids “going sideways” rather than waiting 1-2 hours. With verbal intervention, therapist can wait to restrain and avoid pepper spray, etc. Similar need at Wayne Brown.
- Consider having therapist work for jail and Behavioral Health. Therapist have capability to do crisis intervention.
- More cost effective to certify current Behavioral Health staff person or entry level person. Pay for certification out of MHSA.
- Having a counselor there and available will help avoid most crises. One person split between Juvenile Hall and Wayne Brown. That is the way to relieve pressure and the need for crisis intervention.

Mental Health Court-ACT

- Lael Walz prepared and presented a draft report for the MHSA Steering Committee. The draft uses ACT model (Aggressive Community Treatment) to address people getting out of jail. Follow up transition would be part of plan. Includes identification of specific people and providing specific services to make them function well. To be used for people in the Mental Health Court system. That is how the ACT model works. The services that are provided meet the specific needs of each individual. Supports the discharge system. A team will support continuation of medication, etc. Assessment will identify people who would benefit from ACT services. ACT targets people who are brought to jail over and over. Children’s System of Care wrap around would support residents in Juvenile Hall.
- Hub in community taking care of transitional needs.
- Mental Health Court has stronger case management.
- Still unmet needs because of lack of resources. ACT is logical solution and is just as much for forensic treatment as for the general population where appropriate and applicable.
- Mental Health Court has year of intensive judicial attention. Includes all things that help them do well. ACT can help with follow through.
- Need continued involvement after they graduate. Many times graduates do not do what is in their best interest. ACT provides support one or two years beyond Mental Health Court.
- Identify who needs a more intense level of support and would benefit from ACT. Allows for both volunteer and court ordered participation.
DATE: August 29, 2005

TO: Joan Buffington, Proposition 63 Contractor

FROM: Captain Ken Duncan, Sheriff’s Corrections Division Commander

SUBJECT: Proposition 63 Focus Group Recommendations

Our law enforcement focus group had four meetings. Agencies represented in the meetings included:

Nevada City Police Department
Truckee Police Department
Nevada County Sheriff’s Office

Within the Nevada County Sheriff’s Office the following divisions were represented:

Corrections with representation from California Forensic Medical Group
Patrol

The following personnel attended those meetings:

Nevada City Police Chief Lou Trovato
Truckee Police Chief Scott Berry
Truckee Police Lieutenant Jeff Nichols
Nevada County Sheriff Keith Royal
Nevada County Undersheriff John Trauner
Captain Ken Duncan
Lieutenant Mike Hughes
Lieutenant Tom Carrington
Lieutenant Gary Smith
Sergeant Les Sprague
Sergeant George Kessler
CFMG Medical Director George McKnight
Recommendations

The focus group made the following recommendations as to how our ability to perform services benefiting those needing mental/behavioral services might be improved:

1. Use existing technology to teleconference 5150 evaluations and other behavioral services. Potential sites for placing such equipment may include, but not be limited to, Tahoe Forest Hospital, Sierra Nevada Memorial Hospital, Wayne Brown Correctional Facility, Truckee jail facilities, Juvenile Hall, Behavioral Health offices, Truckee Police Department. The goal of this recommendation is to shorten the amount of time both law enforcement officers and behavioral health clients are involved in 5150 detentions and pre-transportation out-of-service time.

2. Have at least one full-time behavioral health worker assigned to the Wayne Brown Correctional Facility. This position could work a flexible schedule and be on hand to respond as availability permitted, to field situations. The goal of this recommendation is to have trained behavioral health staff in a position to intervene and possible conduct some proactive intervention with incarcerated behavioral health clients. Field availability would potentially add options that may prevent 5150 detentions for both the field law enforcement officer and the citizen.

3. Pool the financial resources that might be available from Proposition 63 funds, from several counties in the area, for a regional facility that would be available to provide services for those in need. This recommendation would provide necessary services to the client and allow law enforcement to have a regional treatment facility to which individuals could be transported to without the expenditure of considerable time and money.
In attendance were Mike Hughes, George Kessler, Ken Duncan, Les Sprague, Gary Smith, John Trauner, Jeff Nichols, Keith Royal, and Julie McManus.

Discussion of priorities took place and the following priorities were identified:

- Full-time counselor/therapist assigned to the jail and Juvenile Hall. Also support law enforcement officers on the street. Counselor could also respond in the field with law enforcement officer. A therapist in both facilities is critical on the “after” end. Consider appropriate shift for counselor to be most effectively utilized. This person could help with continuum of care. Communicate with psychiatrist to insure needed psychiatric medications are given.
- Consider use of technology for evaluations – video conferencing. Ridge Family Medical Clinic is set up for this.
- Crisis evaluation intervention. Find more appropriate location. Jail not most appropriate location. Need medical clearance.
- Support Truckee’s need for crisis worker. Consider telepsychiatry.
- Consider those with dual diagnosis.
- Consider creating a regional facility serving several counties to provide inpatient services to the mentally ill.

Ken Duncan expressed a willingness to take the lead, using input from meeting participants, to create a proposal for group approval to be submitted to the MHSA Steering Committee by the Law Enforcement Focus Group.

Selection of Steering Committee member(s) is pending. Ken Duncan will organize one more meeting before submitting the proposal for the Steering Committee. He will send out a reminder email prior to that meeting.
THE NEVADA COUNTY MEDICAL STAKEHOLDERS GROUP PROPOSAL FOR IMPLEMENTATION OF PROP. 63

GOAL

Reduce the incidence and severity of psychiatric emergencies in Nevada County and enhance access to timely psychiatric and mental health services for all county residents regardless of their ability to pay.

STRATEGIES

1). Create an integrated behavioral health system for Nevada County which will increase timely access for the most vulnerable, low income clients to needed mental health services through the integration of mental health and primary care services.

2). Increase access to psychiatric consultation through telepsychiatry consults. Enhance the knowledge base of emergency care providers, hospitalists, and emergency room staff to maximize treatment efficacy when psychiatric emergencies erupt and the treatment must be initiated within the acute medical hospital system.

THE PROBLEM

The recurrent themes which emerged in our focus group highlight the frustration of sorely limited access to psychiatric services for mental health patients in crisis. For lack of other treatment facility, once a mental health client has been cleared medically through our emergency department (ED) they frequently remain for the bulk of the day while effort is underway to secure a bed at an accepting psychiatric facility. Unfortunately, SNMH's ED is chronically underbedded, even for the seriously medically ill of our community, and devoting precious bed space for hours on end to high impact mental health clientele is most disruptive to emergency department operations. Staff is frustrated, other patients greatly inconvenienced and mental health clients denied timely and appropriate care. There are no local psychiatrist in town who will routinely consult In hospital due to low or no reimbursement rates. Thus, emergency room and hospital staff and physicians are, by default, left to muddle through, as best they can with inadequate training, facility, and resources.

Other discussed areas of need involve the lack of services for our community seniors who exhibit behavioral crisis, and the bias against providing mental health services to these clients with the agest assumption that persons over 65 must be experiencing signs of dementia or delerium. Even when psychiatric symptoms persist after medical intervention and treatment, the causal factor is assumed to be dementia in persons, and access to mental health services denied. Many of these individuals have a long history suggestive of a chronic mental illness which has gone unandized due to lack of services or avoidance of psychiatric care.

Mental health treatment for the dually diagnosed is another seriously underserved area which hugely impacts medical systems, especially the hospital's ED when clients arrive in the delerium of withdrawl or a drug induced psychosis. It seems most of the county's self medicating psychiatric patients have gone largely untreated as their lifestyle choices and chronic substance abuse clouds the diagnosis and treatment picture. To date, our behavioral health department has largely dismissed substance abusing individuals from service, effectively divorcing a large population of dually diagnosed clients from treatment.

The above issues converge to place a huge, undue burden upon the emergency department and hospital/medical stuctures. A bustling emergency room, bustling with too few private spaces is simply the wrong
venue to manage and treat the psychiatric patient who is in crisis. It is unfair to every individual involved nor does it allow for private, respectful or skilled treatment for the mental health client. Another crisis evaluation space must be developed.

PROPOSED SOLUTION

In the absence of accessible psychiatric services in our community and given the long wait for psychiatric evaluation and counseling through the Dept. of Behavioral Health, it is proposed that enhanced training be made available for selected staff members at both Miners and Sierra Family Medical clinics and amongst selected SNMH and Tahoe Forest Hospital physicians and staff. Specialized training at our community medical clinics would support the provision of more responsive and timely access to mental health services with the goal of averting or reducing psychiatric emergency altogether. Sierra Family Medical Clinic has already implemented an exciting and productive model of integrated medical/mental care in which all patients seen in clinic are screened for depression and other psychiatric issues in addition to the usual medical exam. Physicians and clinic staff have received specialized training in psychiatric care and psychotropic medications. A licensed clinical social worker is available to all patients for counseling and mental health support services. Psychiatry service is available several days a week through their clinic. This model of integrated medical/mental health care can be applied community wide with the effect of earlier access and intervention averting the number for frank psychiatric emergencies. The trickie down effect of this early intervention will ultimately relieve the burden upon hospital structures. When psychiatric emergencies do erupt and land in the ED, having specially trained physician and hospital staff available to intervene will increase efficacy and immediacy of treatment for the stabilization of symptoms. These goals support increased sophistication and sensitivity to the needs of the low income mental health clients most likely to land in the ED or hospital for emergent stabilization of their symptoms. It will also serve as a "stop gap" measure until an alternate, more appropriate crisis evaluation site can be developed to ease the burden on already stressed hospital systems.

The hospital already owns and operates teleconferencing equipment. It is additionally proposed that monies be allocated to create contractual arrangements between the hospital and offsite psychiatry to provide psychiatric consult service for the ED or hospitalized patients whose illness warrants immediate specialty intervention. This allows for psych. diagnosis and stabilizing treatment to begin even before transfer to psychiatric setting.

BUDGET

Sierra Family Medical Clinic received integrated health training through a grant administered by No. Sierra Rural Health Network (NSRHN). Through discussions with their administrative director and based upon the costs of Sierra Family Medical Clinics training costs, the following budget projection is submitted. NSRHN is one possible local resource which exists to help administer these trainings and to facilitate planning.

Estimated initial training program cost is projected at 50,000 which would encompass 2 in-person training sessions of four hours each, in addition to four one-hour video conference trainings with expert instructors in this field of Integrative medicine. Anticipated participation is for up to 100 individuals countywide. Additional trainings likely will be necessary both to keep learnings fresh and train new personnel. Additional grant monies might ultimately be available through private foundations to assist in trailblazing this model for communitywide integrative health systems, but key stakeholders from various sectors would need to be committed and involved in this process (ie. Nev. Co. Dept. of Behavioral Health, the community clinics and hospitals.) Additional technical assistance would be necessary to provide continued administrative support should grant help be sought. Administrative support will also be needed to organize and facilitate key meetings of multiple stakeholders to envision and implement the development of the models needed infrastructure. NSRHN would be one possible resource to continue administrative oversight and their technical assistance is billed at $75/hr. (These ongoing administrative costs along with psych teleconferencing contracts costs have been factored in to above estimate.)

EXISTING RESOURCES

The hospital already has teleconferencing equipment and capability. The hospital meeting rooms could be scheduled for use during training dates. Both hospitals and community clinics are already members of No. Sierra Rural Health Networks and have access to member benefits. Pharmaceutical companies could be asked to sponsor the training events through the provision of lunch for the participants. As a modest start towards the development of a local crisis unit, a collaborative effort between key stakeholders could be achieved through use of one of existing modular structures. Dept. of Behavioral Health staff could then staff
and stage 5150 evaluations from this new site until transfer to psychiatric hospitalization is successfully achieved. Telepsychiatry consults could also be staged from this area, and the emergency department thus relieved of its default role as psychiatric crisis treatment site.

Original Message ----
From: Gail Gordon
To: rlloyd@chw.edu ; srsibils@chw.edu ; vjohnston@chw.edu ; Sharon.Turner@chw.org ; Katy.Eckert ; cedarose@earthlink.net ; L.Starr@Hofo.org ; andrea_skeen@hotmail.com ; jdwlaw@ncen.net ; pinewoods@sbcglobal.net
Sent: Wednesday, August 24, 2005 4:10 PM
Subject: MINUTES FROM E.R. STAFF MEETING/FOCUS GROUP

At the Medical Focus Group meeting that took place yesterday, the suggestion was made to email members of the Medical Focus Group the notes from the E.R. Focus Group that met on August 8. Hopefully, they will be helpful as the Medical Focus Group finalizes their proposal to the MHSA Steering Committee.

Gail Gordon
913-9947

No virus found in this incoming message.
Checked by AVG Anti-Virus.
MENTAL HEALTH SERVICES ACT (Proposition 63)
FOCUS GROUP MEETING NOTES #2
Sierra Nevada Memorial Hospital
August 3, 2005 (3-4:30 p.m.)

MEDICAL

Joan Buffington reviewed the planning process and the MHSA questionnaire currently being circulated in Nevada County. Individuals and organizations are invited to write brief written proposals for the use of Proposition 63 funds, due September 1st.

Four Focus Groups (Seniors, Adults, Youth, and Children) began meeting in June. Each Focus Group will choose two consumers to serve on the MHSA Steering Committee. Make-up of the Steering Committee was explained. Applications to be a member of the Steering Committee are due on or before August 19. Each Focus Group will also write a paper identifying priorities/programs that are their highest priorities.

Those in attendance included Karla Nix, Steve Sibilsy, Andrea Skeen, Lael Walz, Erin Rose, Katy Eckert and Barbara Chestnut.

The group decided to focus on two areas of concern:

1. Overload on Emergency Room. Being used as a “holding tank”. Need to help people so they won’t have to go to E.R.

   Older people are being housed at Sierra Nevada Memorial Hospital because of a lack of other services.

Demand on Emergency Room

- Spending time and resources on individuals who are not medically ill. They just have no place else to go. Impacts delivery of medical care.
- Expensive to maintain critically mentally ill. Behavioral Health is “pushing off” this responsibility on to the hospital. Don’t devote resources to creating new soft outpatient services. Refocus responsibility for acute psychiatric patients on the public sector. (Nobody wants to take these patients.)
- People don’t want to be in E.R. when they are in mental health crisis.
- E.R. staff spends time with substance abusers in drug-induced psychosis. Dual diagnosis is difficult situation for hospital.
- Goal of total transformation of mental health system. What we are doing now doesn’t work. Need organic analysis. Many medical doctors not trained in mental health or dual diagnosis.
- Use primary physician to identify who will be responsible and how it will work.
- Collaborate with rural clinic to increase mental health services. Leverage dollars better. The Sierra Family Medical Clinic model is working well. Service delivery in one location. Hopefully, this collaboration would help in keeping people out of E.R.
- Consider use of telepsychiatry. (Dr. Rubenstein is available two days a week at Sierra Family Medical Clinic.) Technology is in place all over county and is not being used. Use at crisis level. Need agreed upon by various stakeholders.
Demand on Emergency Room (Continued)

- In addition to use of telepsychiatry, need presence of a medical doctor in order to prescribe medications if necessary. Consulting psychiatrist.
- Need help managing a patient in-house while the bureaucratic wheels are turning.
- Mental health training for practitioners in the community so there would be “trickle down,” decreased use of E.R. Use telepsychiatry for psychiatric emergencies.
- Outside doctors (in addition to Sierra Family Medical Clinic and SNMH) could use telepsychiatry.
- A “vision” is a Family Resource Center (24/7) that would accept and deal with psychiatric emergencies.
- In proposal, include psychiatric training for E.R. and/or Hospitalist staff.

Needs of Older People

- Complete lack of services for seniors. Bias against delirium/dementia. Behavioral Health doesn’t want to be involved with dementia.
- Hospital ends up with geriatric patients and has no resources.
- County needs to participate in better coordination of service. Need cooperation to access a solution.

Proposal

Nancy and Steve will work on a proposal from the Medical Focus Group for submission to the Steering Committee.

Final Meeting

Date: Tuesday, August 23, 2005 (3:00 p.m.)
Location: Outpatient Building Conference Room

REMINDER: Need two providers for Steering Committee; one for adults/seniors, one for children/youth. Applications for MHSA Steering Committee due August 19. There are also open seats. Steering Committee will meet for six (6) consecutive Wednesdays, 5-7 p.m. starting September 7th.
Those in attendance included Jill Locks, Chris Braun, Roger Lloyd, Stephanie Hendricks, Kaye Holworth and Joe Britton.

Discussion took place, and the following priorities were identified:

- Collaboration with neighboring counties. One crisis center 24/7 serving all of these counties.
- Consider delivering 5150 clients to Behavioral Health for evaluation during business hours. (E.R. not safe place for 5150 client or E.R. staff. Need lock-down facility so individual will not harm other patients. Disaster waiting to happen.)
- Identify a dedicated place for 5150 clients separate and away from emergency room.
- Psychiatrist available 24/7 for hospital staff to consult with. Medicating mentally ill individuals requires special and intensive training. E.R. staff are limited in their knowledge of psychiatric medications.
- Identify ways to manage those presenting with dual diagnosis. Methamphetamines create great potential for harm.
- Consideration of the mobile unit now located next to E.R. It will be vacated in a few months. Discussed possibility of Sierra Nevada Memorial Hospital providing the physical facility and Nevada County Behavioral Health providing staff. Question of liability issues. Advantages of having crisis unit near E.R. for medical clearance, yet separate – best for all clients and providers.
- Acute grief counseling.
- Critical stress debriefing support group for firefighters and/or police officers.

At this time, no one offered to develop a written proposal from the E.R. Focus Group for the MHSA Steering Committee.

Roger Lloyd will be the E.R. Focus Group representative on the MHSA Steering Committee.
EXECUTIVE SUMMARY
NAMI ardently supports the elements expressed in the Mental Health Services Act (MHSA) and the vision of a transformed mental health system where services are consumer and family driven. As Nevada County's only organization for families and consumers, our primary concern is that quality treatment and supports are accessible and affordable for children and adults who have serious mental illnesses. These illnesses are brain disorders and not anyone's fault. They often strike before one has the financial means to deal with these potentially debilitating medical illnesses. Many adults and older adults have experienced untreated illness for years due to stigma and insufficient treatment. We have direct experience where our families and friends have not received the treatment they need to prevent death and minimize disability. We know the real risk for exploitation and trauma. This must change.

For the County's Steering Committee planning to be successful, several key issues called out in the State Department of Mental Health (DMH) Community Services and Supports' (CSS) Three-Year Program and Expenditure Plan Requirements document need to be addressed:

- Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports. (Page 14-15)

- In creating a plan and selecting strategies that will transform a local mental health system into a comprehensive community-system that is client- and family-directed, culturally competent and recovery/resiliency oriented, it is important to think about the current culture of the county system and how it is perceived by a variety of stakeholders. Planning Checklists are included in the Technical Assistance Document 3 and 4 and are intended to be learning tools, to help stakeholders think about the concepts and principles underlying a transformed system, and review the current functioning of their local systems of care in relation to these concepts. (Page 25)

- In this initial plan, counties may request ongoing funding for any or all of the three categories and may request one-time-only start-up funds in any of these funding areas. For the three-year planning period, DMH requires that counties request a majority of their total CSS funding for Full Service Partnerships, in order to begin to provide full service to as many individuals/families as possible. Services funded from General System Development or Outreach and Engagement funds provided to individuals who have full service partnerships may be counted in achieving this requirement. Exceptions for Small Counties: Small Counties are required to request a majority of their total CSS funding for Full Service Partnerships by Year 3 (FY 2007-08). (Page 8-9)

NAMI welcomes a comprehensive discussion of issues and strategies through the Steering Committee process. For too long funding has been inadequate and services are sorely lacking. Now that can change.
NAMI's View
A recent National Institute of Mental Health (NIMH) funded study, the National Comorbidity Survey Replication (NCS-R), found that “half of all lifetime cases of mental illness begin by age 14 and three quarters have begun by age 24.” We were not surprised and recommend that children and young adolescents receive individualized help through the development of a Children's System of Care wraparound program that demonstrates a real commitment to empowering families and which addresses serious mental illnesses that occur in children. Integral to the program is the services of a board-certified child and adolescent psychiatrist experienced in diagnosing and treating serious mental illnesses, a service not currently available in our county. Disease education for the patient and family is a necessity. Families need a peer family advocate to help them navigate disparate community systems. Our children must be better supported in their education and have a real opportunity to succeed. Crisis prevention, therapy, and disease education must be available in juvenile hall. Transitional aged youth must receive the individualized assistance they need to optimize their independence and future through an ACT program (described in next paragraph). Seamless access to treatment as adults is imperative. Suicide prevention is vital.

NAMI recommends that adults and older adults have access to a similar program of individualized support as expressed in AB2034 and discussed in the MHSA state guidelines. Services that include peer support are essential. Assertive community treatment (ACT), and when needed, assisted outpatient treatment (AOT) ensure that recipients receive the mobile, multidisciplinary, 24/7 services to support recovery while preventing hospitalizations, incarcerations, homelessness, and death. These services must be available to the person served wherever he or she lives. Better treatment and crisis prevention services are needed in the jail and for those caught in the criminal justice system. Mobile crisis services for those experiencing a psychiatric emergency are needed. As a person ages and can experience multiple health concerns, integrated treatment between general medical practitioners and specialists, including psychiatry is crucial.

For all ages, integrated services for co-occurring mental illness and addiction disorders (COD) are imperative. Our local Behavioral Department indicates that the number of its adult patients with COD is between 80 to 90%. The risk is clear. Services must accept a person where he or she is, not waiting for a person to reach the "proverbial bottom." There are researched effective strategies to intervene and help the consumer in his or her recovery process. Treatment must include assertive outreach utilizing motivational interviewing techniques that support and engage the consumer, along with active treatment, and relapse prevention services.

In order to transform our public mental health system, NAMI recommends that a hard look be given to the delivery of mental health services, including crisis services and overall treatment strategies. NAMI supports the President’s New Freedom Commission on Mental Health report that “reecommends developing a Rural Mental Health Plan.... An important goal for this plan would be to fully integrate mental health into existing infrastructure for rural public health.” (Page 54) A separate mental health system perpetuates stigma, which is a major barrier to treatment and leads to discrimination. The current model being implemented at Sierra Family Medical Services is exciting and promising. We commend Miner's Clinic for now having psychiatric services.

NAMI also recommends that the implementation of MHSA funded services be overseen by a local committee of stakeholders who would be responsible to monitor adherence to MHSA requirements, to evaluate program effectiveness, and to assure accountability.
BACKGROUND
NAMI Nevada County was founded in 1985 and is the local affiliate of NAMI National, the National Alliance on Mental Illness. NAMI’s mission is to improve the quality of life for all persons who have been impacted by brain disorders commonly called serious mental illnesses including schizophrenia, bipolar disorder, major depression and anxiety disorders. Our primary objectives are to provide peer support and education to individuals and families, to educate the community towards removing the stigma and ignorance associated with mental illness, to advocate for improved services, and help translate scientific knowledge into public policy.

In addition to our 20-year support program for families with adults who have a serious mental illness and our 17-year adult consumer support group, NAMI has provided a support program for families of children, teens, and young adults for the past five years. Our membership includes individuals and families who have a broad experience in the mental health services arena. Many of our families have direct experience with County mental health services; others receive services from the private sector.

We know those who cannot access services directly because they are too sick to be able to do that. Some can’t overcome debilitating symptoms to obtain help. Others suffer from anosognosia, which is the inability of a person to realize, or accept, that he or she has a mental illness. This lack of insight has long been believed to stem from defensive denial, partly because of the stigma associated with these diseases. While denial can contribute to some people with mental illness refusing treatment, research shows that lack of insight just as frequently results from the underlying brain disorder itself. The brains of those who suffer from this particular symptom of mental illness are often structurally different from those who do not. Treatment refusals stemming from lack of insight are thus not "informed medical decisions." It is the malfunctioning of the brain itself that causes the impaired decision-making, and affects approximately 50% of those with schizophrenia or bipolar disorder.

ANALYSIS
The cost to the community for not providing sufficient services is very real and can be measured by human suffering and loss of life, as well as repeated emergency room visits, hospitalizations, institutionalizations, incarcerations, failed school performance, inability to obtain or maintain employment, separation from families, and homelessness.

It is imperative that as a caring community we help those who have difficulty helping themselves. Evidence-based practices exist that lessen or eliminate debilitating symptoms of mental illness, and which minimize or prevent recurrent acute episodes of the illness. Many individuals need help to meet basic needs and enhance the quality of their lives, with the goal of improved functioning in social and employment/school roles, thereby enhancing their ability to recover and live independently.

Children
For a parent whose child develops a serious mental illness, the world never is the same. Families grieve and become overwhelmed, as the illness can become all consuming. These children can be very fragile, yet the symptoms of their illnesses are too often considered bad behaviors that are
ANALYSIS – Children (continued)

within the child's control. Parents can be blamed inappropriately. Unfortunately families often face a significant lack of support in community systems in our county. Other family members and friends often don’t understand—traditional family support systems can be ignorant, and not helpful. Family access to appropriate diagnosis, treatment, education, and support is essential with mental health professionals who understand serious mental illnesses. A peer advocate to assist families navigating community systems is needed. Having the services of a child and adolescent board certified psychiatrist is crucial in the early intervention and treatment of serious psychiatric illnesses in children; there is no one with that expertise in our county. Suicide prevention starts now.

Transitional Age Youth
Mental illness commonly strikes at this age, yet adolescents and young adults with a serious mental illness face an often-overwhelming lack of support in community systems in our county and commonly experience school failure and/or inability to find/keep a job. The illnesses often lead to hospitalization, peer and family problems, out-of-home placement, and homelessness. Youth want to be independent, but the illnesses can have significant impact in their ability to manage independence. Youth can easily become isolated, risk substance abuse, and exploitation. Suicide prevention and disability prevention are major issues. One third of the youth in NAMI’s program for families with children and transitional age youth have become involved in the juvenile justice system. Better school support and improved treatment services in juvenile hall and jail are crucial. Youth transitioning into adult services need to be welcomed.

Adults
Adults with serious mental illnesses face numerous challenges due to these illnesses which can result in personal suffering, inability to work, difficulties managing independence, isolation, homelessness, frequent emergency medical care and hospitalizations, involuntary care, exploitation, institutionalization, incarceration and suicide. Preventing psychiatric emergencies is critical to stopping the disease progression. Research shows that recurrent psychotic, manic and depressive episodes lead to brain damage. Crisis services need to be more accessible. Integrated treatment for addiction is critical. Often forgotten are the families where a parent has a serious mental illness who needs help and support in raising her children, who are also at risk of developing these often hereditary illnesses. Children of mentally ill parents need education, support, and coaching that could be of clear benefit if they later manifest symptoms themselves. Because 40% of those with a serious mental illness can become involved in the judicial system, better treatment services in the jail are needed as well as more support and funding for the mental health court, with the goal of diverting ill people to treatment services before they are incarcerated for minor crimes that are due to illness. Outreach services must reach those in need wherever they are. Too many do not receive what they need.

Older Adults
Older adults have the highest risk for suicide, and it is well established that suicide can be directly correlated with depression. Additionally, due to lack of sufficient treatment and stigma, older adults who have struggled most of their life may not have received appropriate treatment.
ANALYSIS—Older Adults (continued)

Depressive symptoms can mistakenly be considered as symptoms of dementia. The multiple health concerns must be coordinated by an integrated medical service approach. A full spectrum of diagnostic services followed by appropriate treatment is essential; to do otherwise is agist and discriminatory.

Service Delivery
MHSA allows our community to explore new services and new services delivery systems. It is well established that serious mental illnesses are brain disorders and can typically require complex medical treatment. Adult and child patients with these illnesses can have or are at risk for developing other major medical problems including diabetes, heart, kidney, and liver abnormalities. Therefore, it is in the best interest of the patient that the medical treatment for both the brain and other bodily systems be coordinated within the same health care facility/system.

One model is the Veteran’s Administration where a patient goes to the same clinic to see his psychiatrist, attend his support group or education classes, and see his diabetes specialist, internist, or general practitioner. A similar perspective is expressed by the American Academy of Pediatrics that, in describing the risks associated with inadequate mental health care for children, advocates the medical home approach where the pediatrician is the center of health services, including coordination with specialized psychiatric care.

In order to transform the mental health system and provide sufficient health services for our families and citizens with serious brain disorders in our county, we consider the general medical community, including Sierra Nevada Memorial Hospital, Miner’s Medical Clinic, Sierra Nevada Family Medical Services, and Tahoe Forest Hospital as essential partners. We also welcome collaboration with other non-profit agencies that can help provide services.

RECOMMENDATIONS
NAMI recommends significant constructive changes to current mental health services both in content and delivery for children and adults with serious mental illnesses in Nevada County. We recognize that change requires many factors, most importantly a commitment by those who are in a position to effect change. We are hopeful that our community has the collective will to transform the current mental health system in our county. It is the right thing to do.

CHILDREN

Need: Sufficient treatment for children with a serious mental illness

Recommended Strategies:
1. Services of a board certified child and adolescent psychiatrist experience with serious mental illnesses.
2. Affordable therapy with psychotherapists experienced with serious mental illnesses.
RECOMMENDATIONS FOR CHILDREN (continued)

3. Disease education so families can learn how to help their children learn how to manage these very difficult to manage illnesses.
4. Parent support, because the stress in helping children who struggle with a serious mental illness is enormous.
5. Disease education for teachers and principals so our children are supported and have a real opportunity to succeed in school.
6. Peer family advocate to help families navigate community systems.

Need: An effective integrated community system to help and empower families with children who are struggling with serious mental illnesses

Recommended Strategies:
Develop a Children's System of Care wraparound program that demonstrates a real commitment to empowering families, consistent with State guidelines which affirm that families or caregivers of these children are full participants in all aspects of the planning and delivery of services. Enrolled children will have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs within the least restrictive, and normative environment that is clinically appropriate. Respite will be available for families and children who need it. Agencies involved will receive training in disease process.

TRANSITION AGE YOUTH

Need: Sufficient treatment for adolescents and young adults with a serious mental illness

Recommended Strategies:
1) Access to a board certified child and adolescent psychiatrist who is experienced in treating serious mental illnesses.
2) Affordable therapy with psychotherapists who are experienced in treating serious mental illnesses.
3) Education so families can learn how to help their children learn how to manage these very difficult to manage illnesses. Parent education programs typically do not adequately address the disease processes involved.
4) Parent support because the stress in helping children who struggle with a serious mental illness is enormous.
5) Peer family advocate who can help the family and patient navigate the community systems they face: medical treatment, the school environment, and, unfortunately for some, the justice system. All of these systems are difficult to learn, each with its own language and processes.
6) For those patients who are older and appropriate, access to a peer support program.
7) Respite care when the family cannot adequately manage and the child needs a safe, treatment-supported, and appropriate environment.
RECOMMENDATIONS FOR TRANSITIONAL AGE YOUTH (continued)

Need: Effective integrated community systems to help and empower young adults and families with adolescents who are struggling with serious mental illnesses

Recommended Strategies:
1) Develop a Children's System of Care with wraparound services that demonstrate a real commitment to empowering families. (See Children section for description)
2) Provide access to an Assertive Community Treatment or Assisted Outpatient Treatment program (see Adults for description) for TAY who need it.

Need: Smooth transition to adult psychiatric services

Recommended Strategies
1) A youth who is turning 18 who is currently in treatment for a serious mental illness must be able to immediately access a psychiatrist, and not face barriers to medical treatment.

ADULTS (AND TRANSITIONAL AGED YOUTH)

Need: Diminish the disabling and potential lethal risk to individuals with a serious mental illness who have difficulty accessing traditional mental health services. These individuals experience or are at risk for homelessness, frequent emergency care/hospitalizations, and recidivism in the criminal justice system

Recommended Strategies:
Consistent with AB2034, establish an Assertive Community Treatment (ACT) program with a high staff-to-client ratio of no more than 10 clients per team member. ACT is an evidenced based, successful treatment model in which recipients receive the multidisciplinary, 24/7 staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, peer support, addiction, and vocational rehabilitation.

Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers.

Targeted individuals would include those who are eligible regardless of their legal status. Assisted Outpatient Treatment (AOT) is court-ordered ACT and would help those who need that level of support.

Need: Employment supports that foster a sense of purpose and productivity for adults who are struggling with managing a serious mental illness

Recommended Strategies
1) Job training/search/coaching and employer education and support as needed
RECOMMENDATIONS FOR ADULTS (continued)

Need: Help for parents with a serious mental illness who have minor children

Recommended Strategies:
1) Parenting education, support, and coaching for adults with a serious mental illness who have children, while also linking families to needed services and supports if symptoms of illness develop in their children.
2) Education and support for children to better understand their parent's illness.
3) Respite opportunities for children of ill parents when needed.

OLDER ADULTS

Need: Diagnosis and effective treatment of serious mental illnesses in older adults.

Recommended Strategies:
1) On-site or collaborative services with primary care health clinics and health care services which reduce barriers to access and increase integration of physical health care and mental health services.
2) Home/mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities or other factors.
3) Disease education for the client and family or other caregivers.
4) Disease education and consultation by a psychiatrist with primary care providers to increase coordination and integration of mental health and primary care services.

GENERAL NEEDS ACROSS AGE LEVELS

Need: Improved treatment to those with a serious mental illness in the county jail or juvenile hall

Recommended Strategies:
1) The County needs to ensure that continuity of medical treatment continues for a person with a serious mental illness diagnosis while incarcerated.
2) Treatment in the jail and hall needs to be improved by having clinical staff who can monitor medical treatment, provide psychotherapeutic support, and disease education to those who are ill. The staff member(s) also need to have the authority to hospitalize a person undergoing a psychiatric emergency.

Need: Mobile crisis intervention services to persons experiencing a psychiatric emergency

Recommended Strategies:
1. Establish a mobile crisis intervention program utilizing mental health clinicians to accompany trained law enforcement officers who respond to a person experiencing a psychiatric emergency.
GENERAL NEEDS ACROSS AGE LEVELS (continued)

Need: Effective integrated treatment for persons with a co-occurring mental illness and chemical dependency

Recommended Strategies:
1) Integrated assessments for chemical dependency and psychiatric illness for all patients.
2) Skilled clinicians who use motivational interviewing techniques to establish a therapeutic alliance that engages the client in treatment.
3) Integrated individualized plans that include a spectrum of treatment options: cognitive behavioral therapy, psychopharmacology, intensive case management, relapse prevention therapy, maintaining a recovery perspective, monitoring psychiatric and addictions symptoms, stage wise treatment, dual recovery self help groups.

Need: Diagnosis and effective treatment of serious mental illnesses in adults in integrative health care settings.

Recommended Strategies:
1) On-site or collaborative services with primary care health clinics and health care services which reduce barriers to access and increase integration of physical health care and mental health services.
2) Disease education and consultation with a psychiatrist for primary care providers in order to increase coordination and integration of mental health and primary care services.

IN FUTURE FUNDING PHASES
We recognize that MHSA funding is phased, with the current requirement for direct services, defined as Community Services and Supports by the State Department of Mental Health, with subsequent opportunities to meet needs for training, education, prevention, early intervention, innovative programs, as well as capital and technology improvements.

When additional MHSA monies are made available for facilities we would like to forecast at this time three recommendations:

Need: Appropriate facility for persons experiencing a psychiatric emergency

Recommended Strategy: Establish a crisis center where a person who is experiencing a psychiatric emergency can go and receive appropriate assessment and help, including medical treatment.

Need: Appropriate residential facility for adults with a co-occurring mental illness and addiction disorders

Recommended Strategy: Transform the existing Odyssey House to a facility with an on-site program that provides for individualized treatment to meet the unique and specific needs of adults with co-occurring mental illness and addiction disorders. Staffing must include licensed personnel with demonstrated competency in mental health and addiction evidence-based treatment techniques in an integrative and supportive manner.
FUTURE RECOMMENDATIONS (continued)

Need: Sufficient affordable and supportive housing for families and adults with serious mental illnesses

Recommended Strategy:
Create more permanent and affordable housing supports and provisions where tenants have access to an array of support services that are intended to support housing stability, recovery and resiliency, but participation in treatment and supportive services is not a requirement for tenancy.

CONCLUSION
During NAMI's own process of soliciting input from our members, there were issues that came up that that would not require significant funding. The main emphasis was that existing services be provided in a more consumer/family friendly system which is consistent with the intent of MHSA. Most significantly is the expressed need that personnel at Behavioral Health realize that by the time consumers and families ask for help, they and the families have experienced real trauma—mental illness is traumatic to the patient and family, requiring a multi-faceted treatment and services response. Consumers and families need to feel valued and supported for taking the step to get help. Consumers need to feel respected while receiving help. Research shows that a consumer without family support is six times more likely to relapse. Families can help, and need to feel respected as well.

In a consumer and family driven transformed system, consumer-run services are essential. NAMI supports programs such as currently provided by SPIRIT which provides an array of services that increase consumer knowledge and empowerment.

We are concerned regarding the inconsistency of crisis services and that there be a thorough discussion regarding crisis services delivery. We have family members who have needed to be hospitalized and were not. We are familiar with the legal requirements and suggest that our community address the way crisis services are delivered. We are concerned that crisis personnel understand the inclusion of AB 1424, whereby a person's psychiatric history is factored when hospitalization is being considered.

Recovery is a process by which a person with persistent, possibly disabling disorders recovers self-esteem, self-worth, pride, dignity, and meaning through increasing his or her ability to maintain stabilization of the disorders and maximizing functioning within the constraints of the disorders. Lowered expectations is a form of stigma. Stigma leads to discrimination. This must change. NAMI is hopeful that our community truly embraces the MHSA vision and principles. It is the right thing to do.