Doug Bond, Joan Buffington, et al:

Thanks for reformattting the MHSA proposal to match budget worksheets with the narrative for each plan. It does help the review process. Good job!

I have some minor editorial comments which I will share with you at next meeting opportunity (e.g., the 15% admin. adder).

I have some added concerns that I think are worth sharing with BHD as well as the entire steering committee (Joan, is my distribution list current?).

1) I question the decision to have the children/youth wraparound services managed directly by county rather than a contract agency. It was my understanding from our committee and sub-committee meetings that this issue was as yet unresolved and that the committee consensus was to go with a contract provider. In the interest of moving forward I recommend we leave that question open for further discussion, rather than implying that the steering committee has agreed to go with BHD management/staff for kids wraparound services. I would be very interested in hearing from other committee members on this issue.

2) Co-occurring substance abuse disorders/serious mental illness. I believe it is important to clarify that treatment for those people who are "dually diagnosed" must be integrated, not separated as if two unrelated conditions. The point is that
special training is needed for staff to treat this very common situation, and that those afflicted recognize the interrelationship (stigma, shame and blame should be better dealt with!). Have we allowed for that in our MHSA budget planning?

Regarding the kids wraparound issue, I had the pleasure today of renewing my acquaintance with a friend from my Santa Clara County NAMI and MHB days (mid-nineties) before moving to Nevada County in 1998. Jerry Doyle, Executive Director of Eastfield Ming Quong ("EMQ", Santa Clara County youth treatment provider agency), has been very active in mental health treatment issues for kids, and is an effective advocate for wraparound services (the children's version of Assertive Community Treatment, "whatever it takes, whereever and whenever it is needed" - especially in the home and with the whole family). Jerry was the first to implement kids wraparound services at EMQ back in 1993! I believe Jerry has resource information of value to Nevada County on this wraparound issue and have asked him to send me his list. We might even be able to persuade Jerry to come to Nevada County and help educate us on the history and latest technology? Incidentally, Jerry is on the Governor's MHSA commission, and his specialty is reviewing county MHSA proposals for their kids wraparound programs. One point, for example, is that funding for these programs may qualify under child welfare (in lieu of group home living), which comes to us at only 5% county cost (compared to 50% under Medical for MH services). Thanks to Carol Fuller Powell (Charis Youth Center Executive Director and on our MHSA Steering Committee) for making this contact and sharing with NAMI (Lael Walz) so I had the opportunity to renew an old friendship!

Rod Pence

PS to Jerry Doyle, thanks for your time on the phone today. As I explained, I am more involved in MH treatment for adults than kids. Lael Walz, our NAMI Nevada County President, is our youth MH treatment specialist, as of course is Carol Powell of Charls, as you know. But please send me the data we discussed and Lael/Carol will take it from there.
Nevada County MHSA Proposal
SPIRIT / PEER

Iden Rogers  March 14, 2006

p. 13 -- Peer counselors at SPIRIT Mental Health Peer Empowerment Center, through an independent contract with NCBH, provide and support outreach efforts.

p. 2 -- Nevada County contracted with SPIRIT Mental Health Peer Empowerment Center to provide outreach to un-served and under served populations. In addition, the County contracted with the SPIRIT Center Outreach Director as Lead Facilitator for the Community Input process.

p. 6 -- Nevada County Department of Behavioral Health contracted with the Outreach Coordinator of SPIRIT Center to act as lead facilitator of the MHSA community input process.

Should there be consistency in these “contract” / “contracted” terms?

p. 11 -- The Youth Focus Group included: Charis Youth Center, SPIRIT Center, Sierra Adoption Services, NAMI, Community Recovery Resources (CoRR), FREED, Hospitality House, Alta Regional Center, NC Probation, NC Behavioral Health, individual consumers and family.

SPIRIT was not represented in the Youth Focus Group as reported by some in attendance. Andrew Skeen was there but not representing SPIRIT.

p. 25 -- SPIRIT Peer Supportive Services – Peer driven and staffed empowerment center focused on the SMI individual. First year average 15 contacts per week, second year 22, and third year 30 individual contacts.

Lily would be interested in knowing if these figures came from the SPIRIT quarterly reports or from where?

p. 6 -- This small rural community includes a client base of peer counselors at the new SPIRIT Mental Health Peer Empowerment Center, other consumers at SPIRIT, and ... .

p. 25 -- SPIRIT Peer Supportive Services – Peer driven and staffed empowerment center focused on the SMI individual. First year average 15 contacts per week, second year 22, and third year 30 individual contacts.

SPIRIT just completed its second year on Gates Place on February 9, 2006 with doors open to the public.
Is “First year,” “second year,” “third year” consistent with SPIRIT’s opening date?

Might “relatively new SPIRIT” be better?

Peer counseling training at the B.H. modular building did precede SPIRIT’s existence.

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p. 83 -- Facilitated by the NCBH staff liaison who, with the original Peer Counselors, developed the peer counseling training class and manual. Co-facilitated by a Peer Counselor.

There are now “manuals” (plural / three). So, on p. 83, it needs to be changed to “manuals.”

The training consists of twelve weekly sessions plus assignments. Staff Liaison as facilitator, two trainings, twelve weekly sessions each.

Lily says she gives no assignments. She feels it might be better stated: “The training consists of twelve weekly sessions which include interactive role-play.”

Lily says, “Staff Liaison as facilitator, ONE four-hour training per week, for twelve weekly sessions.”

Just for info: SPIRIT uses these three names for the three courses:

- Core Volunteer Ed Class 100
- Peer Counseling 101
- Group Facilitation 102

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p. 82 -- Clients who drop in to the SPIRIT Center in need of immediate support would be seen by a Peer Counselor; a Peer Counselor is a graduate of the SPIRIT Center twelve week Peer Counselor Training who receives supervision through participation in the weekly Mutual Support Group.

Lily says, “.... Peer Counselor Training who receives supervision through participation in the weekly Mutual Support Group meetings, Staff Meetings, and on the spot -- as needed.”

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p. 82 -- Clients who drop in to the SPIRIT Center in need of immediate support would be seen by a Peer Counselor; a Peer Counselor is a graduate of the SPIRIT Center twelve week Peer Counselor Training who receives supervision through participation in the weekly Mutual Support Group.

p. 83 -- The training consists of twelve weekly sessions plus assignments. Staff Liaison as facilitator, two trainings, twelve weekly sessions each.
It needs to be mentioned that the Peer Counseling training module must be preceded by a SPIRIT Orientation training module of one four-hour training per week for six weekly sessions.

It needs to be mentioned that there is also a Group Facilitation training module of one four-hour training per week for twelve weekly sessions.

Putting it together, would this be better?

Clients who drop in to the SPIRIT Center in need of immediate support would be seen by a Peer Counselor. A SPIRIT Peer Counselor is a graduate of the SPIRIT Center twelve week Peer Counselor Training, preceded by a six week Core Volunteer Training, and often succeeded by a twelve week Group Facilitation Training -- who receives supervision through participation in the weekly Mutual Support Group meetings, Staff Meetings, and on the spot -- as needed.”

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p. 83 -- Staff liaison will facilitate weekly Mutual Support Group for individual support and case presentations by Peer Counselors.

Lily feels that this language is more appropriate and factual:

Staff liaison will attend and supervise peer-facilitated weekly Mutual Support Group meetings for emotional support of Peer Counselors and supervise peer-facilitated case presentations by Peer Counselors.

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p. 83 -- Ongoing education and training of new peer counselors and expansion of services to isolated communities ensures community-promotion, empowerment, and reinforcement of these values.

Not sure what “community promotion” means? Promote the community like the Chamber of Commerce would do?

How about:

Ongoing education and training of new peer counselors and expansion of services to isolated communities would help to promote client, family, and community awareness, promote self-empowerment, and help in stomping out the stigma of mental illness.

----------

p. 83 -- The SPIRIT program will advance the goals of recovery and empowerment by providing peer services to individuals and their families in a non-threatening community setting.

Lily strongly prefers positive terms like:
The SPIRIT program will advance the goals of recovery and empowerment by providing peer services to individuals and their families in a safe, friendly, accepting, home-like community setting.

Opinion: NAMI Nevada County is far better prepared to offer meaningful support to families than is SPIRIT.

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p. 16 -- Older Adults

Access - Isolation is a major issue for older adults. Outreach and community based program delivery is needed to engage this population. Peer programming seems indicated as an intervention.

What is “Peer programming?”

Is either of these any better?

“Peer counseling seems indicated as a component of the intervention.”

Or,

“Counseling by older adult peers seems indicated as an intervention.”

(“Peer counseling” doesn’t always necessarily mean SPIRIT peer counseling, of course.)

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p. 60 -- Two local bilingual, bicultural community members would be trained and certified as peer counselors. Anger management, domestic violence, and substance abuse would be the focus of classes given by the peer counselors with an emphasis on how these issues affect the SED/SMI individual and their families.

It appears that there is a Peer Counselor Certification training in Sacramento relating to domestic violence and sexual assault.

From Weave, Inc. who offers courses – “The Peer Counseling Certificate course satisfactorily completes the California state mandated training for peer counselors to work under the auspices of domestic violence and sexual assault.”

And, from Sierra College: ADM.JUS. 200 - DOMESTIC VIOLENCE AND SEXUAL ASSAULT INTERVENTION “Meets state certification requirements for domestic violence and sexual assault counselors. Covers historical, cultural, and psychological factors, precursors and effects, relationship of substance abuse, cultural diversity and role expectations, responsibilities and processes of medical, mental health, law enforcement, courts, and advocacy professionals. Covers crisis intervention and counseling techniques. Examines legal issues, mandated reporting, protective orders, victims' rights and available resources.”
This leaves anger management and substance abuse peer counselor training and certification.

But then, if state-mandated training and certification, like through Weave, Inc., is not what is meant on page 60, then, I suggest that the word “certification” be removed. SPIRIT, for example, has no credentials to offer certifications for anything.

I can see a peer counselor becoming familiar enough with these different areas (anger management, domestic violence, and substance abuse) to be able to competently refer people to community resources already established in these areas.

I can see a peer counselor offering basic informational presentations in these areas but prefer they not be called “classes.”

So, for page 60, might it be better to say:

Two local bilingual, bicultural consumers would receive and complete peer counselor training. Among their duties, they would make informational presentations on anger management, domestic violence, and substance abuse to persons with SED/SMI and their families and to explain how these issues can be caused by or exacerbated by emotional illness.

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pages 71, 75, 77, 79, and 80 -- Peer Specialist

“Peer Counselor” is defined on page on page 82, subject to revision, but “Peer Specialist” is not defined.


On Proposal page 80, would it be helpful for it to read:

Funds for staffing. Staffing categories include: Team leader (MA in related field or license), Psychiatrist, Registered Nurses, Peer Specialists (as defined in NAMI’s A Manual for ACT Start-Up, 2003), and Masters level staff (related fields).

Also, “Team Leader” is a job title, so L in “Leader” needs to be capitalized.
March 9, 2006

Stephen Mayberg  
Department of Mental Health  
1600 9th Street, Room 151  
Sacramento, CA 95814

Mental Health Services Oversight and Accountability Commission  
1600 9th Street, Room 151  
Sacramento, CA 95814  
MHSOAC@dmh.ca.gov

Re: Nevada County Community Services and Support Three-Year Program and Expenditure Plan (Nevada CSS Plan)

Dear Dr. Mayberg and Commissioners:

Protection and Advocacy, Inc. (PAI) submits this letter opposing the use of Mental Health Services Act (MHSA) monies to fund involuntary outpatient commitment (AB 1421 plans) as proposed in the Nevada County Community Services and Supports Three Year Plan. In addition, PAI opposes Nevada County’s proposal to use of MHSA monies to fund a mobile crisis team that appears to include paying for the salary of law enforcement who are members of the team while performing law enforcement functions.

As you know, PAI is the federally mandated disability rights organization. PAI operates statewide to enforce the legal rights on individuals with disabilities. Our legal advocacy staff addresses individual rights violations and systemic issues through education, training, and direct representation, investigates allegations of

"Advancing the human and legal rights of people with disabilities."
abuse and neglect, and advocates for the enforcement and advancement of disability rights on a local, state and federal level.

Although you have not formally received the Nevada County’s Community Services and Supports Three-Year Plan at this time, we expect that Nevada County will nonetheless submit their proposed plan as written. The County’s MHSA representative and Board of Supervisors are copied on this letter and will receive this letter within the time period for public comment on the Nevada Plan. Our agency expects that you will continue to review Community Services and Support (CSS) plans carefully to determine whether proposals are consistent with the purpose and intent of the MHSA and satisfy the requirements for CSS plan development as set forth in the Department of Mental Health’s “MHSA CSS Three-Year Program and Expenditure Plan Requirements for Fiscal Years 2005-2008.” (DMH CSS Plan Requirements)

I. PAI Opposes Nevada County’s Proposed Use of MHSA Monies to Fund Involuntary Outpatient Commitment as a Violation of Both the Intent of the MHSA and the Client and Stakeholder Involvement Requirements

We are aware of an agreement between Nevada County and the family of Laura Wilcox in which there was agreement that Nevada County would apply for and obligate MHSA monies to implement the expansion of involuntary outpatient commitment. The Board of Supervisors issued a resolution stating that the county will apply for MHSA funds to implement involuntary commitment back in September 2004, outside and before the start of the community input process for the Nevada Plan (May 1, 2005 to September 2005), as stated on page 3 of the Nevada CSS Plan. PAI’s objection to Nevada County’s proposed use of MHSA funding for this purpose are twofold:

1. The MHSA Funding of Voluntary and Innovative Services is Not Satisfied by Implementation of Involuntary Outpatient Commitment (AB 1421 Plans)

The State Department of Mental Health’s CSS Plan Requirements specify the voluntary aspect of any service to be funded under MHSA: “Individuals accessing services funded by the [MHSA] may have voluntary or involuntary legal status
which shall not affect their ability to access the expanded services under this Act. Programs funded under the [MHSA] must be voluntary in nature.”

Funding for positions to help implement further involuntary mental health services with MHSA monies violates the voluntary element of the MHSA and cannot be funded with MHSA monies. Expansion of involuntary outpatient commitment contradicts the purpose and provisions of the MHSA which are to promote innovative, voluntary, community-based services and support the Wellness and Recovery models.

Section 7 of the MHSA provides in part:

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connection, self responsibility, and self-determination.
(2) To promote consumer-operated services as a way to support recovery.
(3) To reflect the cultural, ethnic and racial diversity of mental health consumers.
(4) To plan for each consumer’s individuals needs.

2. MHSA Requires Stakeholder Involvement at all Phases of Plan Development

As reported in newspapers, Nevada County entered into an agreement with the Wilcox family prior to September 28, 2004. On September 28, 2004, the Nevada County Board of Supervisors declared in a resolution its intent to implement an involuntary outpatient commitment program by stating in relevant part:

“...Whereas, a source of funding for the [Assisted Outpatient Treatment] Demonstration Project could be authorized through the ‘Mental Health Services Act’ Initiative, which has qualified for the statewide general election on November 2, 2004. Now, therefore be it resolved, as follows:

It is hereby declared that Nevada County will apply for funding made available pursuant to the Mental Health Services Act, in
the first funding cycle [2005-06], if the initiative is adopted by the voters of this state...”

(See Nevada County Counsel letter, September 28, 2004; Board of Supervisors of the County of Nevada Resolution #04-462, dated September 28, 2004. Attachment # 1)

In the summary comments to the Nevada CSS Plan, it provides, “Some funds are intended to implement Laura’s Law as required by an agreement between Nevada County and the family of Laura Wilcox.” The Nevada CSS Plan seeks to hire new staff to assist in implementing outpatient commitment, by hiring a new .50 FTE Licensed Mental Health Professional at $5000 for years 2005-2006 (Nevada CSS Plan, pages 27, 93-98), and a new therapist/case manager for 2006-2007 at $27,516, and for 2007-2008 for $27,516 (Nevada CSS Plan, pages 99-102).

In effect, Nevada County obligated monies under MHSA, without community input through an earlier agreement and subsequent resolution, and outside its authority under MHSA.

Since the passage of MHSA, the Department has supported client and community input while understanding and appreciating that the purpose of the MHSA is to fund innovative, community based services that are not “business as usual.” Consequently PAI urges the Department to reject Nevada County’s proposed use of MHSA monies for the purpose of funding involuntary outpatient commitment because a settlement agreement is not an appropriate or lawful mechanism for developing a CCS plan. The County had obligated funds well before the start of the community input process (May 1, 2005 to September 2005). We understand from participants in Nevada County’s community input process that MHSA funding for involuntary outpatient commitment was presented to participants as a “done deal.”

The Department of Mental Health’s requirement of community involvement is spelled out clearly in the DMH CSS Plan Requirements which state that clients and family members are to be an integral part of any CSS proposal, rather than permitting a county to, on its own, obligate MHSA monies. Essential elements for all CSS plans are five fundamental concepts which “must be embedded and continuously addressed throughout” the plans, including-

- Community collaboration: community collaboration refers to the process by which various stakeholders including groups of
individuals, families, citizens, agencies organizations, and businesses work together to share information and resources in order to accomplish a shared vision...

- Wellness focus, which includes the concepts of recovery and resilience: Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities...Resilience refers to the personal qualities of optimism and hope...

(DMH CSS Plan, pages 5-6)

II. PAI Opposes the Implementation of an Involuntary Outpatient Commitment Scheme in Nevada County Because the County has Failed to Demonstrate that it has Satisfied the Requirements Set Forth in Welfare & Institutions Code, Section 5345 et seq.

The Department is well aware of the requirements of implementing an involuntary outpatient commitment program through AB 1421. Even if the Department finds that the MHSA monies can be used to fund portions of an involuntary outpatient commitment scheme in Nevada County, Nevada County has failed to demonstrate that it has met the requirements necessary to implement an involuntary outpatient commitment program.

The requirements of an AB 1421 program are codified in Welfare and Institutions Code sections 5345-5349.5. These sections provide that counties must satisfy several components before implementing an involuntary outpatient commitment program. These requirements include the following:

- The County Board of Supervisors must determine that “no voluntary mental health program serving adults, and no children’s mental health program, may be reduced as a result of implementation” of outpatient commitment at the local level. [Welf. & Inst. Code § 5349].

- The County Board of Supervisors and the local mental health director have a duty to consult with stakeholders – including client, ethnic and citizen constituency groups – to consider whether to expand forced treatment in the county. [Welf. & Inst. Code § 5348, subd. (a)(2)(A)].

- A county that moves to implement AB 1421 must show that it has adequate resources to provide housing and the full array of community support services for persons with psychiatric disabilities [Welf. & Inst. Code §5348].
Such assistance must include provision for “housing clients that is immediate, transitional, permanent, or all of these.” [Welf. & Inst. Code § 5348, subd. (a)(2)(J)], keeping in mind that persons have a right to “[l]ive in the most independent, least restrictive housing feasible in the local community.” [Welf. & Inst. Code § 5348, subd. (a)(4)(A)]. This includes the availability of services provided by “[c]ommunity-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member...” [Welf. & Inst. Code § 5348, subd. (a)(1)]. For persons with children, they have a right “to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as appropriate.” [Welf. & Inst. Code § 5348, subd. (a)(4)(A)].

- Additional housing requirements prior to the expansion of forced treatment includes: the requirement that the county show that it can offer and provide “the same [housing and community support] services on a voluntary basis.” [Welf. & Inst. Code § 5348, subd. (b)]. This includes access to substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans’ services provided by staff with the requisite cultural background and linguistic skills. [Welf. & Inst. Code § 5348, subd. (a)(2)(B)].

These are but a few of the requirements Nevada County must satisfy prior to implementing an involuntary outpatient commitment plan under AB 1421 with the additional requirements of ensuring that there are specific due process rights in place.

(See CARES Coalition letter on AB 1421 Implementation, Attachment #2)

III. MHSA Monies Cannot Be Used to Pay for Law Enforcement Salaries as Part of the Mobile Crisis Team When Performing a Law Enforcement Function.

The Mental Health Services Act specifies that funds shall be utilized to expand mental health services. Police officers, even those responding as part of a mobile crisis team who are performing a law enforcement function, may not have their salaries and any costs associated with this law enforcement function reimbursed under MHSA. The Department of Mental Health (DMH) has issued documents reflecting its position that MHSA monies cannot fund police officer salaries or equipment by stating:
All of the mental health costs for staffing and providing new or expanded services are allowable under the MHSA. In addition, costs for training of law enforcement personnel and for the evaluation of new or expanded services are also allowable. Costs for the law enforcement officers themselves are not allowable cost as they are usually paid for by law enforcement jurisdiction, consistent with their existing responsibilities. In addition, other costs usually born by law enforcement when responding to police calls, such as police cars, radios, administrative costs, etc. cannot be funded under MHSA.

(See DMH Frequently Asked Questions for the Community Services and Supports Component (CSS), November 22, 2005, Attachment #3)

The Nevada Plan under its “Mobile Crisis Intervention/Jail” proposal seeks to expand its existing crisis service: “The mobile crisis intervention team will consist of a mental health worker and law enforcement officer responding as a team to mental health crisis in the community...” If, as it appears, Nevada County is seeking to fund law enforcement positions using MHSA funds, we would urge the Department’s rejection of this proposal as an inappropriate use of MHSA funds.

Further, there can be no supplantation of existing funds for law enforcement duties which is to currently respond to mental health crisis situations under the Welfare and Institutions Code. The Mental Health Services Act specifies that funds “shall be utilized to expand mental health services.” These funds shall not be used to supplant existing state or county funds utilized for mental health services. Peace officers have an existing duty to respond to crisis calls, including those related to individuals with mental health needs. These responsibilities include assessing the individual and their situation to determine the need for emergency intervention and detaining and transporting individuals who require involuntary emergency intervention. Shifting this responsibility from several officers to a few specifically designated and trained officers does not create a new service or an expansion of services. (See DMH Letter No. 05-04 Mental Health Services Act-Non-Supplantation, July 18, 2005, Attachment #4)

In conclusion, PAI expects that the Department and Commission will continue to uphold the purpose and intent of the MHSA by not approving Nevada County’s CSS Plan to implement a program of involuntary outpatient commitment. Client voice was not heard when the County directed the local mental health department to seek funding under MHSA. Nevada County has failed to demonstrate that it has met the requirements set forth in Welfare and Institutions Code, sections 5345 et
seq. Additionally, PAI opposes the use of MHSA monies to fund law enforcement officer activities as a violation of both the letter and intent of Mental Health Services Act.

Sincerely,

[Signature]

Suzanna Gee
Associate Managing Attorney

Enclosures:

- Nevada County Counsel letter, September 28, 2004; Board of Supervisors of the County of Nevada Resolution #04-462, dated September 28, 2004;
- CARES Coalition letter on AB 1421 Implementation; DMH Frequently Asked Questions for the Community Services and Supports Component November 22, 2005; DMH Letter No. 05-04 Mental Health Services Act-Non-Supplantation, July 18, 2005

cc: Doug Bond
    Project Director, MHSA
    Nevada County Department of Behavioral Health
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    Robert Erickson, Director
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Robert Erickson  
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10433 Willow Valley Road, Suite A  
Nevada County, CA 95959  
March 13, 2006

RE:  Response to Nevada County’s Mental Health Services Act (MHSA) Proposal

The California Network of Mental Health Clients (CNMHC) has concerns about the inclusion of AB 1421 (Laura’s Law), involuntary outpatient commitment, in Nevada County’s three year plan for Community Services and Supports from MHSA funding.

It is our belief that involuntary outpatient commitment is not allowable under the MHSA nor the California Department of Mental Health’s (CDMH) requirements for counties’ Community Services and Supports plans. As the CDMH correctly stated, “Programs funded under the Mental Health Services Act must be voluntary in nature.” However, we will concentrate our concern about the inclusion of Laura’s Law in Nevada County’s plan on why the MHSA should not, rather than can not, include forced treatment options.

First and foremost, the MHSA promises a transformation of the mental health system, with services that transcend outdated and stigmatizing reactions to people with mental disabilities. Involuntary treatment looks backwards, not forwards. Whereas the conventional system has used coercion and force in its attempt to solve problems, a transformed system would create alternative options that maximize client self-determination and autonomy, goals of the MHSA. The implementation of the MHSA should support a new direction for mental health services, not look back to the same old – unsuccessful – answers.

Secondly, the MHSA clearly intended these funds to be earmarked for voluntary community services and supports only, and this is underscored both in the promises that were made to key constituents and in the Act’s underlying principles. The goal was to fulfill the promise made 30 years ago when the institutions were largely closed: to provide an array of voluntary holistic services in the community. In fact, the services that provided the model for the MHSA (the adult and older adult components) AB 34 and 2034, are designed to be voluntary, and require providers to follow a client-directed, culturally competent and recovery-based standard of service. The California Council of Community Mental Health Agencies, one of the lead advocates of the MHSA, writes that “the law (AB 34/2034 programs) describes a process of developing an individual personal services plan in which each client participates. These are voluntary community services programs. There is no authority for using Proposition 63 funds for any other type of program. The imposition of involuntary treatment precludes such standards.”
Thirdly, using MHSA funds for involuntary treatment may drive communities of color away from the mental health system. Many Latinos and other people of color already distrust the "system", because of involuntarily treatment and bad treatment. The use of Prop 63 monies for involuntary treatment will only rekindle their mistrust of state-funded services. Moreover, court-ordered treatment under Kendra’s Law in New York, upon which AB 1421 is modeled, has disproportionately targeted people of color, specifically, African Americans and Latinos. A recent analysis of state data by the New York Lawyers for the Public Interest showed that African American clients were nearly five times as likely as whites, and Latinos were twice as likely as whites, to be the subject of court ordered treatment under Kendra’s Law. ¹ For an County to fund a similar involuntary outpatient commitment program would invite a comparably discriminatory application of court-ordered treatment, violating the principle of cultural competence as well as civil rights.

The spirit and intent of the MHSA is captured in Section 7, 5813.5 (d) of the Mental Health Services Act:

(d) Planning for services shall be consistent with the philosophy, principles and practices of the Recovery Vision for mental health consumers.

1. To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
2. To promote consumer-operated services as a way to support recovery.
3. To reflect the cultural, ethnic, and racial diversity of mental health consumers.
4. To plan for each consumer’s individual needs.

The inclusion of an AB 1421 program in any county’s Community Services and Supports plan violates this spirit and intent of the MHSA.

Finally, it is difficult to understand how an agreement between Nevada County and the family of Laura Wilcox is consistent with community input, which is required to be the source of Community Services and Supports plans.

Sincerely,

Kitty Zinman
Executive Director, CNMHC

CC: Doug Bond, Project Director
Joan Buffington, lead facilitator
Nevada County Mental Health Board

http://community.webtv.net/stigmanet/kendraslaw
From: "William J Toensing" <toensing@theunion.net>
To: "Robert Erickson" <Robert.Erickson@co.nevada.ca.us>
Date: 3/17/2006 10:33:44 AM
Subject: Transition Age Youth.MHSA

March 17, 2006  Dear Bob

I would like to recommend that the Charis Youth Center be considered as the core entity around which a TAY project could be formed. They have the infrastructure in place and Carol Fuller Powell has been involved in the local MHSA process every step of the way. I understand Jeff Brown toured the facility last Wednesday and I plan to do so soon. While Spirit is well-meaning in its intent, they do not have the professional expertise, i.e., licensed, trained therapists, etc., to undertake such a monumental task. As you know, I have years of experience in this arena, both as a professional and family member. Crisis assessment was my strong suit, I've waited until this time to make a formal statement after carefully examining what has been presented so far. I am making this request as an individual who is deeply concerned over the paucity of services in Nevada county for transition age youth, ages 16-25. Sincerely yours, Joan L. Rogers-Toensing, M.A., M.F.T.

CC: "Doug Bond" <doug.bond@co.nevada.ca.us>, "Joan Buffington" <joan.buffington@co.nev.us>

[Handwritten note: "Joan T. Input"]
Hi Joan,

I just read the MHSA press release posted on yubanet and it reminded me that I need to talk about this. If the press release had stated "In Nevada County, consumers and family are a majority of the 29 members MHSA Steering Committee that discussed and agreed unanimously in concept on the twelve plans" I wouldn't be alarmed. The inclusion of "in concept" doesn't mislead the way the current press release does. The press release leaves me feeling lied about. "Being lied about" is such an alarm button for me and that is an intrapersonal trait from being raised with an undiagnosed, mentally ill sibling. To be raised in a circumstance where a loved one-sibling misleads consistently about another has enormous impact on the developing self-esteem of the other being mis implied about. It is a sabotaging development and thus not something that rolls off me easily. I have such an enlarged need to not be misimplied about which I can separate from playful storytelling. There are several areas in the 12 plans that I do not endorse and I look forward to further work on those areas. I share this in honor of the endeavor to be transparent.

It is a snow day here (no school) and really dumping. Taxes are mostly done and I do love shovelling diamond dust. See you tomorrow.

Mary
Response to the County’s Mental Health Services Act Proposal

NAMI commends Nevada County for its efforts towards transforming the public mental health services into a consumer and family driven system that is based on proven, cost effective practices with the goal of improving the quality of life for children and adults with mental illnesses and their families. We recognize that the Mental Health Services Act (MHSA) requires an approach to services delivery in a new way that won’t happen overnight, and that this is an evolving process that requires commitment, training, and continual evaluation.

We also commend the County for bringing together various community stakeholders and its commitment to continuing the Steering Committee. We thank the stakeholders for coming to the table through the Steering Committee process, and respect their commitment and involvement.

NAMI supports the concepts behind each of the 12 proposed programs. We commend the State Department of Mental Health (DMH) for mandating the full service partnership concept where the specific needs of children and adults are addressed on an individual basis, and we commend the County for stipulating the Assertive Community Treatment model that is evidenced based. We praise the Family Unified Court for its willingness to see that children and families in conflict are assessed for mental illness and that the children will be followed into the school environment for coordination of support and services. We applaud the support for SPIRIT Peer Empowerment Center. It is essential that services be culturally competent and accessible to all people, and outreach and engagement with Latino communities occur. We are excited that Sierra Nevada Memorial Hospital will do follow-up connections for those who come to the Emergency Department for a psychiatric emergency evaluation and are sent home. It is imperative that services are available through Laura’s Law to those who do not have the insight to their illness. We laud the involvement of Sierra Family Medical Clinic and the Community Collaborative of Tahoe Truckee. It is about time that crisis intervention support will be available at the jail and crisis workers will go out with law enforcement to the location of the person experiencing the psychiatric emergency.

The resulting proposal is a strong effort; however, it just begins to address what individuals and families with mental illnesses face in our community, a reality that NAMI knows on a daily basis. One million dollars is not enough to transform a system whose goal must be more than treating the symptoms of mental illness; it must be to improve the lives of people living with mental illnesses.

We recommend that the proposal integrate the intent of specific outcomes as expressed by DMH such as family preservation, suicide prevention, and a commitment to assist with employment, education, and housing.
Other recommendations are:

1. Include representatives from the High School District and Community College in future Steering Committee’s activities.

2. Centralize the administration of the Child and Adolescent Psychiatrist, the coordination of Wraparound services, and the provision of the Peer Family support services by contracting these programs to a Community Mental Health Provider to optimize the coordination of services for children and youth.

3. Ensure that the Peer Family Support is available to the ACT program.

4. Increase services for Transitional Aged Youth (TAY) that specifically target the specialized needs of this population at the outreach, engagement and system development levels. Services must target suicide prevention, integrated treatment for mental illness and substance abuse, housing, education and employment supports.

Our justification for these recommendations is below.

**Planning Process Concerns**

During the Children and Transitional Aged Youth focus group process, the only consumer and family members consistently involved were from NAMI families. We were not able to hear from other families of children and adolescents with mental illnesses who receive services from Children’s Mental Health.

NAMI has conducted a support program for families of children, teens, and young adults who live with mental illnesses everyday; and, over the course of nearly six years, 41 parents have participated. Of those 41 parents, 12 have had direct experience with Children’s Mental Health. Unfortunately, all of these parents felt that their needs were not met, and 11 felt that staff devalued them as parents. Our efforts to address these concerns through the focus group process were received defensively by the staff present and therefore, we cannot support the proposal’s statement on Page Three stipulating that the first objective of the Community Input process was to establish a community discussion that was “open, inclusive, and as transparent as possible, in order to overcome...any attitudes about existing Nevada County Department of Behavioral Health (NCBH) services.” We appreciate that agency and department management are willing to listen to specific aspects of our concerns and look forward to that opportunity.

Additionally, we are disappointed that during the focus group process there was no participation from the education community, and that through the Steering Committee process there were no representatives from the major high school district, where most adolescents with mental illnesses are involved. There was no participation from our community college which serves the young adult age level where mental illness traditionally strikes. Those voices were missed. We support this being rectified in future Steering Committee processes.

**Coordination of Services to Children, Adolescents and Their Families**

When the onset of mental illness symptoms occur, the stages of the process for a family is a crisis in itself. The individual is trying to deal with his or her daily symptoms, frightening, embarrassing, unknowing and the horrendous stigma accompanying it. The family becomes enmeshed in this crisis and often does not realize, let alone understand that they are looking at a biological brain disorder. The symptoms make it appear that the person is now a “bad person acting out” or is on drugs, and when reasoning previously alleviated a situation, it is no longer
part of the solution. Their once friendly son or daughter is reduced to a person in mental anguish. Families need support from those who understand and can help.

NAMI is concerned as to how the Palm Tree program, Wraparound, Child and Adolescent Psychiatrist, and Family support programs administratively interface as the budget detail has each program in separate agency control, with the exception that the Family support program is yet to be determined. We are concerned that families don’t get caught up between systems due to a lack of coherent approach at the operational level.

As a member of the former Children’s System of Care Policy Committee, NAMI did not see in that process an understanding of the issues that families whose children have a serious mental illness face. We are concerned that in order to really partner with families, as required by MHSA and stated in the proposal, that there has to be an appreciation and respect as to how difficult it is for families to help their children who are ill. We hope to see this understanding evolve within the County’s Children’s Mental Health system during the MHSA transformation process. We question its present capacity to operate the Wraparound program.

Additionally, in order to adequately help children with mental illnesses, having the services of a board certified child and adolescent psychiatrist is crucial and we are concerned about the administration of the psychiatrist program. Our families have direct experience and knowledge of this issue and find troublesome the statement in the proposal on page 159: “Board certified Child Psychiatrists are highly trained provide [sic] specialized care for children’s mental illness, and often difficult to locate/recruit.” This is a disconcerting statement as there is at least one child and adolescent psychiatrist who currently comes to Grass Valley each week, and we have been told by a community provider in the Nevada City area that another child and adolescent psychiatrist comes to its facility on a regular basis. Our NAMI families have experience with board certified Child and Adolescent Psychiatrists at Stanford, UC Davis, and in private practice from Auburn, Roseville and Sacramento. We are concerned as to the County’s understanding as to the necessity for this level of service, especially in the context of our NAMI families experiences with Children’s Mental Health services.

We support the current description that has the Child and Adolescent Psychiatrist services be contracted with a Community Mental Health Contract Provider and not be a contracted service as part of the County’s Children’s Mental Health services (which we understand is intended, but not expressed in this document).

Additionally, because of our experience with Children’s Mental Health, we recommend that the Wraparound program not be housed there, but be contracted to a Community Mental Health Contract Provider who has child and adolescent psychiatrist services.

We recommend that the administration of the Peer Family Support program be contracted with the Community Mental Health Contract Provider to ensure continuity of services for families involved. Additionally, Peer Family Support must be available to support the ACT as needed. Support is essential for parents and other family members of persons who have serious mental illnesses, regardless of age (children & youth, TAY, adults and older adults).
We cannot agree with the description on page 160 that states that the Peer Family Support program will not collaborate with community providers for children and youth. Families can have difficulty in coping with community systems and can need peer family support to be able to partner with these systems as is stipulated by MHSA. We hope this is an oversight. Secondly, the fund type for this service is listed on pages 160, 163 and 164 as System Development; however, on pages 165-168 it is listed as Full Service Partnership which is what we support.

**Improved Services to Transitional Aged Youth**

Another area of tremendous concern is the lack of System Development funding for Transitional Age Youth. Only five to seven TAY adults are projected to be served through the TAY Full Service Partnership program (ACT) over the course of the next two years which leaves a huge gap in services available for other TAY adults who are the most at risk for substance abuse and the second largest group at risk for suicide (after older adult males). It is well known that serious mental illnesses strike during the TAY years, and we are concerned as to the current lack of services to this population. According to the statistics on page 20, the County currently serves only one in five projected eligible TAYs. Additionally, after combining the numbers of those served by County Behavioral Health in the TAY, Adult and Older Adult age range, services to TAYs represent only 6.8% of that total. In NAMI, we have a number of TAY families whose youth/young adults are not in the public system, but are certainly at risk of needing public services due to the degree of illness.

At the last Steering Committee meeting, a discussion began on this gap and we support its continuation. TAY individuals need support from clinical staff in learning how to manage their illnesses. Housing is a major issue for this population that has not been adequately addressed. Finding employment is a significant need, yet there are no budgeted funds in any of the proposals for employment supports; nor are there budgeted funds for educational supports. Although the SPIRIT proposal includes services to TAYs, NAMI has concerns that many of TAY individuals’ specialized needs are not able to currently be addressed at SPIRIT.

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We still are concerned, as stated in our initial MHSA position paper, about crisis services, a Crisis facility, and housing supports. It is our experience that AB1424, addressing psychiatric history, needs to be better understood in the crisis evaluation process. Law enforcement needs an alternative to jail for those who need help who may not meet involuntary hospitalization criteria. Better housing supports are needed for individuals to be able to recover.

As the MHSA process continues, NAMI recommends that the County continue to look to our local community resources to provide MHSA funded services in order to enhance the opportunity for individuals with mental illnesses to integrate into our larger community. We are committed to working with the Steering Committee and the County towards achieving a truly transformed consumer and family driven system that addresses stigma and discrimination, and embodies concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
A Modest Proposal

My name is David Moyer. I am a retired Air Force Lt. Col. and a clinical worker licensed in Alaska. I am also an author and distributor of health books. I wish to advocate on behalf of clients today.

As a former employee of Nevada County Behavioral Health I know the frustration of trying to intervene with at risk children by wrapping them in social resources. As I often repeated to my colleagues, I opined that we were adjusting the deck chairs on the Titanic. I have the same concerns regarding this plan. The plan needs to provide lifeboats for our citizens who have been labeled as “mentally” ill. I see a number of innovative programs that will address community needs but I see nothing that will fund better assessments of “mental” disorders or more effective treatments for the same. Is that not what Behavioral Health Services should be about, assessing and treating mental disorders?

As a consumer of these services I come to these recommendations through personal and professional experience. I have a son who could have died twice. The first time was from following the recommendations of his psychiatrist who worked for Nevada County Behavioral Health Services. The second time was a direct result of unenlightened and unprofessional policies and behavior by personnel at Wayne Brown Correctional Facility. My family has a personal stake in the outcome of this process.

My son’s illnesses were never properly assessed, treated, or managed. I am not convinced that adding a new bureaucratic layer of services will help my son or others like him whose illnesses have not been properly assessed and treated. Using some of those funds for improved assessment and treatment will help him and others like him. The current adult caseload is about 1200. If you divided just half of the million dollars by the 1200 adult clients caseload you would get more than $4,000 for each person for diagnostic work-ups and innovative treatments. These funds could be used to identify the particular biological risk factors that lead to the labels we call mental disorders. Many could actually be given definitive treatment for their disorders. Some could be cured.

The current plan does not incorporate the implications of current research for assessment and treatment. A short visit to Google will reveal peer reviewed sources to the following claims. For example, 19% of the general population has antibodies to Lyme disease while 33% of psychiatric patients have such antibodies. Lyme related “psychiatric” disorders are treatable with antibiotics, as attested by the treatment of former Florida Quarterback Wyatt Sexton. Borna Virus exists in 15% of those with major depression, 5% of those with minor depression. It is often successfully treated with Amantadine, an anti viral medication. No one is assessed for Lyme and, I suspect for Borna Virus at Nevada County Behavioral Health Services. Many with atypical depression respond favorably to chromium picolinate. How many depressed clients showing signs of insulin resistance are being so treated? Vitamin, mineral and amino acid supplements work so well for 70-80% of bipolar patients that they do not need to be on medications. How many are given the option of a nutritional approach? The same supplements have resulted in dramatic cessation of temper tantrums in an ABAB trial with an obsessive disordered and a
The following is provided by Janet Garth for the MHSA process who could not be here today and who is a Nevada County resident, member of NAMI Nevada County, and has have a family member with a severe mental illness.

Although it's been about 18 years since the onset of our family member's mental illness, the memory of the onset and following horrific process is still emblazoned in my mind. Unfortunately, today as I attend NAMI meetings and provide phone support for families in crisis, I hear identical stories. Quite amazing to me is that over the many years other members of our family have been diagnosed and treated for cancer, accidents, surgeries, etc., their recovery was so dissimilar. Obtaining a diagnosis and treatment for these illnesses was a reasonable and compassionate process; our doctors working with us made the decisions and process compassionate and less difficult.

When the onset of mental illness symptoms occur, the stages of the process for a family is a crisis in itself. The consumer is trying to deal with his or her daily symptoms, frightening, embarrassing, unknowing and the horrendous stigma accompanying it. The family becomes enmeshed in this crisis as at the onset it is not known that it is a biological brain disorder as the symptoms make it appear that the person is now a “bad kid acting out” or is on drugs, and when reasoning previously alleviated a situation, it is no longer part of the solution. The son or daughter may become threatening, imagines visions and sounds in their brain that is real to them and they no longer resemble the person they use to be. Law enforcement has difficulty in dealing with the ill person: agencies, laws and endless difficulties are
encountered in obtaining hospitalization. The only way you can understand the fear, trauma and hopelessness of serious mental illness is to experience it first hand, or spend a few nights with someone who is psychotic, threatening, suicidal, and yes, you the parent, may become their target. Parents should not have to sleep with locked bedroom doors in fear of their loved one and fear of an illness they do not understand. Their once friendly son or daughter who had good grades and worked and dreamed of a future is reduced to a person in mental anguish.

I painfully recall how long it took before we, as a family, were included in any recovery process. The first psychiatrist who diagnosed our loved one simply said, “you have a mild case of schizophrenia, take this medications and you can do whatever you’d like in life - period” - no words could be more untrue. The ensuing years included traumatic side effects from the older medications, my child became a missing person, a homeless person living in the woods, an arrested person, a person self medicating with alcoholic, a person with a DUI, a 99 lb emaciated 28 year old. Fortunately, we found our way to NAMI who provided compassion and provided all the information they had gathered to work our way through the many mazes of mental illness and agencies.

We will not forget those professionals along our journey who have provided support and who had some clear understanding of the illness. But so many years of ongoing crisis is unconscionable all because a young person, woke up one day with a mental illness through no fault of their own.
And so now it is 2006 - a long way from the 1960's when the state hospitals were closed with no money or services to follow, and we have an opportunity to speak out and let it our voices be heard. The family is the #1 advocate and person who can accurately describe the reality of what their loves one's behavior is, what side effects are noticed and what is working or not. We the families of those with mental illness need services, support and inclusion at the onset. We need counseling by a professional who is educated and understands the brain disorder and its symptoms which produce the behaviors; we need information on medication and side effects, and possible solutions to problems that may arise. We need resource information: when and how to file for benefits, names and phone numbers of related agencies, the number for NAMI, coordination on how to work with Probation.

In conclusion, the deliverance of the Assertive Community Treatment must also include services to the family. It is a family journey, and education is needed to empower ourselves to learn how to navigate through the systems. The family who also lives with the illness should be included in the recovery process through MHSA's fundamental promise to treat those with severe mental illnesses – we, the family, along with medication and wraparound services are the onsite critical facet in this recovery process.
NEVADA COUNTY MHSA PROPOSAL COMMENTS

BY ROD PENCE, MEMBER
NATIONAL ALLIANCE ON MENTAL ILLNESS – NAMI

INTRODUCTION:
I PLAN TO COMMENT ON THE ISSUES OF ASSERTIVE COMMUNITY TREATMENT (ACT), LAURA'S LAW, MOBILE CRISIS INTERVENTION AND HOUSING. FIRST, I WANT TO THANK COUNTY BEHAVIORAL HEALTH STAFF, ESPECIALLY JOAN BUFFINGTON, DOUG BOND AND BOB ERICKSON, AND THE MHSA STEERING COMMITTEE COMMUNITY STAKEHOLDERS, FOR PRODUCING A GOOD MHSA PROPOSAL. THIS IS JUST THE BEGINNING OF WHAT COULD BE AN EFFECTIVE, EVOLVING PROCESS FOR TRANSFORMING OUR MENTAL HEALTH SYSTEM INTO A MORE EFFECTIVE PLAN FOR HELPING THOSE WITH SERIOUS MENTAL ILLNESSES AND THEIR FAMILIES RECEIVE THE SERVICES AND SUPPORTS NEEDED FOR RECOVERY IN THE COMMUNITY.

ASSERTIVE COMMUNITY TREATMENT (ACT):
THE COUNTY MHSA PROPOSAL INCLUDES IMPLEMENTATION OF AN ACT TEAM (WORK PLAN # 4). THE PROPOSAL NOW INCLUDES SUFFICIENT REQUIREMENTS FOR STARTING A MINIMUM SIZE ACT TEAM. HOWEVER, I BELIEVE IT IS ESSENTIAL THAT STAFF QUALITY REQUIREMENTS ARE HIGH TO ACHIEVE SUCCESS. WE MAY
ALSO FIND THAT THE NUMBER OF TEAM STAFF WILL NEED TO BE INCREASED TO ASSURE 24HR/7DAY SUPPORT. I ALSO BELIEVE THAT COST SAVINGS WILL EXCEED EXPECTATIONS AND THAT INCREASED STAFF EXPENSES, BOTH IN SIZE AND QUALITY, WILL BE MORE THAN COMPENSATED BY THESE SAVINGS. EVENTUALLY, I HOPE THAT ALL THOSE IN OUR COUNTY WHO WOULD BENEFIT FROM THE ACT PROGRAM WILL BE SERVED, AND THEY AND THE ENTIRE COMMUNITY WILL BE REWARDED.

I WISH TO ADD THAT THESE ACT SERVICES, "WHATEVER IT TAKES", FOR TAY, ADULTS AND SENIORS ARE ALSO NEEDED FOR OUR CHILDREN AND YOUTH, IN A "WRAPAROUND" PROGRAM (WORK PLAN #1). SERIOUS MENTAL ILLNESSES ARE BECOMING MORE AND MORE PREVALENT AT YOUNGER AGES, AND IT IS IMPERATIVE THAT THESE SEVERE NEUROLOGICAL BRAIN DISORDERS ARE DIAGNOSED AND TREATED AS EARLY AS POSSIBLE TO BETTER ASSURE HIGHER LEVELS OF RECOVERY.

LAURA'S LAW: \textit{A82357 AMENDS (KARNETTE & YEE)}
THE PROPOSAL MAKES A COMMITMENT (WORK PLAN #6) TO IMPLEMENT LAURA'S LAW (AB1421, COURT-ASSISTED OUTPATIENT TREATMENT FOR THOSE WHO LACK THE INSIGHT TO RECOGNIZE THEIR MENTAL ILLNESS AND THEIR NEED FOR TREATMENT), AS MANDATED BY THE COUNTY BOARD OF SUPERVISORS. THE LAW WAS NAMED AFTER
NEVADA COUNTY RESIDENT LAURA WILCOX, WHO WAS ONE OF THREE SHOT AND KILLED AND OTHERS INJURED BY AN UNDERSERVED MENTALLY ILL CLIENT OF BEHAVIORAL HEALTH IN JANUARY 2001. THOUGH THE PROPOSAL FUNDS PROVIDE ONLY ONE HALF-TIME LICENSED THERAPIST TO COORDINATE THE PROGRAM, THE PRIMARY SERVICES WILL BE PROVIDED THROUGH THE ASSERTIVE COMMUNITY TREATMENT (ACT) PROGRAM (REFERRED TO PREVIOUSLY). I EXPECT THAT THE LAURA’S LAW PROGRAM WILL REQUIRE MORE FUNDING AND INTENSIVE COORDINATION TO BE SUCCESSFUL, BUT THE RESULTS WILL BE VERY COST EFFECTIVE AND BENEFICIAL TO THOSE IN NEED AS WELL AS THE COMMUNITY.

MOBILE CRISIS INTERVENTION:
THE PROPOSAL INCLUDES A MOBILE CRISIS INTERVENTION TEAM (WORK PLAN # 7) CONSISTING OF A LAW ENFORCEMENT OFFICER ASSISTED BY A MENTAL HEALTH WORKER RESPONDING TO MENTAL HEALTH CRISIS SITUATIONS IN THE COMMUNITY. AT PRESENT OUR OFFICERS RESPOND TO CRISIS SITUATIONS ON THEIR OWN AND MUST MAKE DECISIONS ON WHETHER INDIVIDUALS IN CRISIS SHOULD BE JAILED, HOSPITALIZED OR RELEASED. THEY HAVE NO OTHER “CRISIS FACILITY” TO TAKE THEM TO, WHEN PERHAPS ALL THE POSSIBLY MENTALLY ILL PERSON NEEDS IS A FEW HOURS OR DAYS WITH PROFESSIONAL MENTAL HEALTH SERVICE CARE (OR MAY
NEED PSYCHIATRIC HOSPITALIZATION TO GET THROUGH A PSYCHOTIC EPISODE. THE OFFICERS NEED THE HELP OF MENTAL HEALTH PROFESSIONALS TO BETTER GUIDE THESE DECISIONS. AND JAIL IS CERTAINLY NOT AN ACCEPTABLE ALTERNATIVE TO TREATMENT. WE NEED A MENTAL HEALTH CRISIS FACILITY AS WELL AS A MOBILE CRISIS INTERVENTION TEAM, ALTHOUGH THAT FACILITY NEED MUST BE CONSIDERED WHEN WE GET TO THE “CAPITAL” PHASE OF THE MHSA PROGRAM.

HOUSING:
A PERSON WITH A SEVERE MENTAL ILLNESS MUST RECEIVE “WHATEVER IT TAKES” IN THE COMMUNITY FOR SURVIVAL AS WELL AS RECOVERY, INCLUDING MEDICAL TREATMENT (PHYSICAL AS WELL AS MENTAL), EDUCATION, EMPLOYMENT, AND MOST IMPORTANT: “FOOD, CLOTHING AND SHELTER”. HOW CAN YOU EXPECT SOMEONE TO RESPOND TO TREATMENT IF THEY ARE HUNGRY AND COLD? HOUSING IS AN ESSENTIAL NEED. THE PROPOSAL DOES NOT BEGIN TO ADDRESS THIS FUNDAMENTAL ISSUE, BUT IT MUST ALSO BE CONSIDERED, ALONG WITH THE “CRISIS FACILITY”, DURING THE CAPITAL PHASE.

THE CURRENT MENTAL HEALTH SYSTEM HAS NOT ADDRESSED THIS HOUSING ISSUE SUFFICIENTLY; “LACK OF STAFFING AND FUNDING” IS AN EXCUSE, NOT A LEGITIMATE REASON, IN MY OPINION. THERE HAS BEEN A LACK OF
COORDINATED EFFORT BY THE COUNTY TO ADDRESS THIS MOST BASIC NEED AND THAT THE COUNTY MUST REACH OUT AND WORK WITH THE LARGER COMMUNITY CREATIVELY AND ASSERTIVELY TO REFLECT THIS NEED THROUGH THE MHSA TRANSFORMATION PROCESS. THE "CONTINUUM OF CARE" APPROACH TO OUR MENTAL HEALTH TREATMENT SYSTEM APPLIES ESPECIALLY TO HOUSING NEEDS.

CONCLUSION:
I DON'T SEE THE NEED TO REVISE THE MHSA PROPOSAL TO REFLECT ANY OF MY COMMENTS, WITH THE POSSIBLE EXCEPTION OF THE WRAPAROUND PROGRAM FOR KIDS. HOWEVER, I HOPE THESE COMMENTS WILL BE CONSIDERED DURING THE ONGOING PROCESS OF IMPLEMENTING THE MHSA PROGRAM.

MY OWN SON, WHO IS IN THE COUNTY MENTAL HEALTH SYSTEM, HAS SUFFERED DIRECTLY FROM THE LACK OF ALL OF THE ESSENTIAL SERVICES DESCRIBED ABOVE. HE IS CURRENTLY IN AN OUT-OF-COUNTY FACILITY, MORE COSTLY AND AWAY FROM HOME, WHEN HE COULD BE TREATED BETTER RIGHT HERE IN HIS OWN COMMUNITY. PLEASE JOIN ME IN HELPING TO ASSURE THESE MUCH NEEDED SERVICES ARE PROVIDED HERE IN NEVADA COUNTY.
From: Annette LeFrancois
To: Joan Buffington
Date: 3/17/2006 2:11:33 PM
Subject: Fwd: MHSA input

>>> "Ann Guerra" <ann@freed.org> 3/17/2006 1:55:14 PM >>>
Annette, I cannot find email (or other, for that matter) addresses for submitting written comments to the plan. Will you please see that my comments get where they need to go? Thank you!
DATE: March 17, 2006
TO: Nevada County Department of Behavioral Health
FROM: Ann Guerra, FREED Center for Independent Living
RE: Nevada County MHSA plan

FREED Center for Independent Living provides advocacy, peer support, housing, independent living skills training, assistive technology and information and referral services to persons with disabilities in Nevada County. FREED provided a representative to the steering committee and requests the following comments to be included as input to the Nevada County Mental Health Services Act plan:

* We support the goals of the MHSA to transform the behavioral health system and we recognize the difficult task this has imposed on Counties.

* Accessibility of services is simply not addressed in Nevada County's plan. The County services and contract service providers should be held to their obligations under the Americans with Disabilities Act not by individuals who need services, but by funders and agencies charged with administering programs.

* The plan falls particularly short on planning for seniors and for transition age youth. Participation from these age groups (and their representatives) was minimal during planning meetings and there was not a significant effort to include them.

* The process for developing the plan involved discussions of proposals that were solicited through an informal process that did not involve a request for proposals. Proposers have no guidance for understanding cultural competency, consumer and family-driven service provision or requirements under the Americans with Disabilities Act.

* There is no plan to integrate cultural competency into the Mental Health system.

* Housing services, critically needed by consumers of mental health services in Nevada County, are not even close to adequately funded. Existing resources are inadequate, but no attempt was made in this process to create an inventory or identify what housing needs exist. Planned services to people who are homeless through MHSA are peer counseling, not housing services.
Involuntary treatment is an inappropriate use of MHSA funding and FREED strongly protests any attempt to include involuntary treatment in the plan.

It is our hope that Nevada County will identify and adopt appropriate outcome measures that reflect the goals and principles of the Mental Health Services Act and will begin to facilitate full participation by consumers and family members in service delivery and governance of plan elements. Thank you.

CC: Doug Bond; Robert Erickson
ADDENDUM IV
NEVADA COUNTY CSS
SEVENTEEN ORIGINAL PROPOSALS
The Need for Mental Health Services for Nevada County Children

Mental Health services for children represent a crucial economic and social investment for our community. Emotional, behavioral, and mental disorders cut across income, education, racial, ethnic and religious groups. In 2000, the US Surgeon Generals' Report stated that one in ten adolescents has a mental illness severe enough to cause some level of impairment; yet only one in five of them receive mental health services in any given year. In recent years, both the Surgeon General of the United States and the President's New Freedom Commission on Mental Health have highlighted the urgency of addressing children's mental health needs.

Detection and assessment of potential diseases and disabilities in children's early life can result in early intervention that will save money and other community resources by possibly minimizing symptoms and promoting the best outcomes for later life. Preventive mental health services for children are especially important, as illnesses and disabilities not treated in childhood can easily become barriers to achievement in school and in society. Young children with Mental Health problems often go unserved until they start school, by which time their needs have become more intense and may require more treatment than if they had been detected at an earlier age. The geographic isolation of many families residing in Nevada County further exacerbates this problem in many instances. Services and providers are less accessible to families residing in rural outlying areas of our county, indicating a strong need for significant effort and resources toward outreach efforts to find and serve these families.

In spite of the clear benefits of addressing the mental health needs of children, it is estimated by the Children's Defense Fund that nationally four out of five children with mental health needs do not receive any help. Many of these children are not adequately screened or assessed so that they can receive appropriate treatment, services, and supports. Barriers to services for children include service delivery issues, including lack of coordination of multiple systems, and a lack of resources. Other barriers to services include: a lack of providers, inadequate reimbursement for professionals conducting mental health screenings, lack of early detection and early intervention, lack of follow-up services, and a lack of coordination of multiple services. Family issues that contribute to barriers to services include limited access for non-English speaking families, transportation barriers, and a reluctance of many families to discuss emotional or mental health issues with strangers.

It is clear that the mental health of local children is a significant concern for professionals working in Nevada County. First 5 Nevada County launched a School Readiness Initiative in 2002. The "Special Factors Analysis" was conducted in local sites with children most at-risk for lagging behind in school. Kindergarten teachers who participated in the initiative identified social-emotional skills as the single most significant challenge facing entering kindergarteners. According to the Grass Valley School District Special Education Coordinator Stephen Burns, the need for early childhood mental health services represents "the largest gap in services to preschool children". Similar research validates a great need for older children as well.

There are those who say that serving children with emotional, behavioral and mental health problems is too costly. Yet the alternative is even more expensive. The human and economic costs of not intervening as early and promptly as possible include the following:

- **Adults with Mental Illness.** Children whose mental health needs go untreated become adults with untreated mental illness, and the severity of mental illness is likely to grow with the person. According to the US Surgeon General, 74 percent of adults with mental disorders had prior problems with mental illness as children and adolescents. The term "emotionally disturbed" is used when addressing the mental health issues of children. These adults are unlikely to become productive members of society and will cost communities greatly. Prevention is much less costly to society, both financially and socially, as adults may become violent to themselves or to others when their mental health needs are untreated over the course of a lifetime.
- **Lost Learning Opportunities.** Children miss out on valuable time in school. Many are too troubled to learn without special help and when they don’t get it, they may negatively impact the quality and quantity of classroom time for all their peers by displaying disruptive behaviors in classrooms.

- **Safety Risks.** When children fall in school and drop out or are suspended or expelled, communities face the prospect of having unproductive youth “hanging out” and engaging in disruptive and possible illegal activities.

- **Diminished Quality of Life.** Mental difficulties often surface during childhood and when they are severe, they are very destructive over a long period of time. This creates enormous suffering for the children and their family members, and all suffer a greatly diminished quality of life.

- **Lost Productivity.** Families often miss work if called to school to address their children’s behavioral problems or if they must stay at home to care for them. Communities lose valuable workers when there is this kind of family disruption. The staggering emotional and financial toll on families can also affect their productivity on the job.

Early intervention is crucial for children with emotional disturbance because it may minimize the progression and severity of disease. (NOTE: that the term “emotional disturbance” is used for children, instead of “mentally ill” in the legislation.) Early intervention requires making early identification and intervention a higher priority: it means that children of all ages must have access to mental health screens and assessments, both on a routine basis and when they display signs of possible emotional, behavioral, or developmental difficulties.

**Children’s Focus Group Proposal**

Children under age 16 represent 16 to 17% of the population in Nevada County. The Nevada County Proposition 63 children’s focus group recommends that a similar percentage of Proposition 63 dollars be used for children in this age group.

The Nevada County Proposition 63 children’s focus group proposes that funds be utilized to fund a Children’s System of Care (CSOC) model that includes Wraparound Services for participating families. The CSOC model is defined as “a comprehensive spectrum of services and supports which are organized into a coordinated network to meet the multiple and changing needs of individuals and their families.” Important components of the CSOC model include multidisciplinary collaboration among agencies serving children, the inclusion of performance outcome measures, a focus on prevention and early intervention, and a continuum of services available to meet the differing needs of mentally ill and emotionally disturbed children. Wraparound services are designed to meet the individual and diverse needs of families by providing a wide range of direct services to family members.

Mental health issues manifest in ways that affect all aspects of children’s lives. A child suffering from poor mental health is likely to have difficulties in school, at home, in the community, and in all other areas in which they operate. As a result, their needs cannot be met solely by the mental health system. In order to assure the best possible outcomes for mentally ill and emotionally disturbed children, it is crucial that agencies serving children act collaboratively within a multi-disciplinary system of care such as the CSOC. These agencies may include special education, child protective services, public health, parents, childcare providers, and juvenile justice programs, as well as public and private mental health providers.

The efficacy of a collaborative approach to serving the mental health needs of children has been confirmed by multiple studies and is recommended as best practice by local, state and national experts. When Nevada County implemented a CSOC model in the past, the number of out-of-home placements and psychiatric institutionalizations was dramatically decreased by placing resources into local levels of care and into the development of “service planning” across agencies.
The Children’s System of Care (CSOC) model reflects a paradigm shift in the way children with mental illness and their families are currently served. The new paradigm reflects best practices in serving children and their families in the most effective, respectful, and cost-saving manner. The following values and practices reflect the CSOC model and differ from the old service delivery model. The CSOC model focuses on the entire family rather than just the mentally ill child. This family-focused approach emphasizes keeping families together and providing what they need to be successful as a unit. Children’s and family’s strengths are emphasized by the CSOC model in place of focusing on the child’s deficits and pathology. Parents and families are viewed as partners in the child’s treatment, rather than as clients. The CSOC model focuses on outcome-based services over intervention.

By putting resources into early intervention and prevention services as well as treatment for seriously emotionally disturbed children, the CSOC model represents a crucial economic and social investment for Nevada County. The financial cost of serving Severely Emotionally Disturbed (SED) children is huge. Psychiatric Institutionalization and treatment for this population is extremely costly. By focusing resources on prevention and early intervention as well as treatment for children with serious emotional disturbance, the CSOC model may minimize the progression and severity of mental illness.

The following components are crucial elements in meeting the needs of Nevada County families with mentally ill children:

- **Training for education staff** (including both childcare providers and school staff) in mental health issues. Training should include the following: resources and referrals available for children and families; Individualized Education Plan (IEP) training (how to implement and respect IEPs in the classroom); recognizing and identifying students with possible mental health issues; sources of support for teachers working with these children; and how to best work with parents of children with mental health challenges.

- **Outreach** to find and serve geographically and socially isolated families in need of children’s mental health services.

- **Wraparound Services** that meet the diverse and individualized needs of families. This may include services for parents with mental illness or drug/alcohol addiction in order to promote parenting that will support children’s development and wellness. Wraparound services may also include a family advocate, transportation, translation, and many other direct services in support of families.

- **Access to a Board Certified Child/Adolescent Psychiatrist**.

It is clear that Proposition 63 funds will not provide enough money to serve all children in Nevada County with mental health needs, however, it is our intention that a representative sample of children be served with the funds by implementing the CSOC model with Wraparound services. Children with critical unmet mental health needs should be served first, but funds should be set aside to be used toward prevention and early intervention services as well. Ideally, Proposition 63 funds can be used as leverage to secure additional funding from other sources to serve additional families in the future.

The CSOC model envisions a continuum of care to meet the diverse needs of the people served. The continuum of care is illustrated in the attached table, which shows categories/levels of need and corresponding services available to emotionally disturbed children and their families. The Nevada County Proposition 63 children’s focus group proposes that a three-year plan be used to reach an equitable investment of resources across the continuum, and that Proposition 63 funds be used to complement, rather than supplant, federal and state funds.
Nevada County Proposition 63
Children's Mental Health
Levels of Needs and Systems for Children’s Mental Health
Note: For all of the following categories, it is important to include translation, housing and transportation support when needed. Also, buy-in and support from schools is crucial.

<table>
<thead>
<tr>
<th>Systems</th>
<th>Most Severely Emotionally Disturbed</th>
<th>Least Severely Emotionally Disturbed</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLES</td>
<td>Systems of Care: Treatment of Severe and Chronic problems</td>
<td>Systems of Early Intervention: Early-After-Onset</td>
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<tr>
<td>Examples of Interventions</td>
<td>Emergency/Crisis treatment</td>
<td>Early identification to treat health problems</td>
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<td></td>
<td>Family Preservation</td>
<td>Monitoring of health problems</td>
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<td></td>
<td>Long-Term therapy</td>
<td>Short-term counseling</td>
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<td></td>
<td>Probation/Incarceration</td>
<td>Foster placement/group homes</td>
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<td></td>
<td>Disabilities programs</td>
<td>Family Support</td>
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<tr>
<td></td>
<td>Hospitalization</td>
<td>Emergency Shelter, Food, Clothing</td>
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<td></td>
<td>Special Education for learning disabilities, emotional disturbance, or other health impairments.</td>
<td>Pregnancy prevention</td>
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<td></td>
<td>Family and Parent Support and Education</td>
<td>Violence prevention</td>
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<td></td>
<td>Drug and Alcohol addiction treatment</td>
<td>Dropout prevention</td>
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<td></td>
<td>Respite Care for parents/caregivers</td>
<td>Learning/Behavior accommodations</td>
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<td></td>
<td>Meds management</td>
<td>Drug and Alcohol addiction treatment</td>
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<td>IEP</td>
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<td>Public Health and Safety Programs</td>
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<td>Prenatal Care</td>
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<td>Child Abuse Education</td>
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<td>General Health Education</td>
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<td>Drug and Alcohol Education</td>
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<td></td>
<td>Parent Involvement</td>
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<td></td>
<td>Conflict Resolution</td>
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</tbody>
</table>
MENTAL HEALTH SERVICES ACT (Proposition 63)
FOCUS GROUP MEETING NOTES #4
Sierra Nevada Children's Services
August 15, 2005 (5:00 p.m. to 7:00 p.m.)

CHILDREN

Those in attendance included Lael Walz, Rich Stone, Jackie Herring, Lee Steffensen, Jennifer Hurst-Crabb, Marcia Westbrook, Karl Snyder, Marina Bernheimer, Mary Graebner, and Katy Eckert.

Marina Bernheimer volunteered to draft the Children's Focus Group proposal for the MHSA Steering Committee. Lael Walz indicated that she would like to make clear that serious mental illness is not preventable, although the progression and severity of mental illness can be minimized.

Priorities that were discussed included:

- Systems of prevention (primary prevention) including low-end needs and low cost.
- Systems of early intervention including violence prevention, school dropout prevention.
- Support of chronic and severe problems including high-end needs with crisis intervention, family preservation, assisting consumer in getting out of juvenile hall or hospital, and special education for emotionally disturbed.
- Wrap around services as philosophical model. Target small, specific group for wrap around or children's system of care. Includes interaction of agencies and collaboration between them. Soft money, support people talking to each other. Direct services come from wrap around. Vehicle to get other funding. Leverage.
- Education in the school system. Help teachers and administrators recognize mental illness through the use of inservice training. Help teachers feel they can have support with students who are mentally ill.
- Independent advocate (who is separate from funding source for sake of independence) to do outreach for people who are not equipped to identify resources for their children. Agencies trained to do outreach. SMART is one way. Structure as a “campaign” rather than knocking on doors. Use flyers and newspaper articles to let people know something is out there.
- Access to a board certified child and adolescent psychiatrist for diagnostic services, etc.

Members of the MHSA Steering Committee will be Jennifer Hurst-Crabb and Lael Walz.
PROPOSITION 63

YOUTH FOCUS GROUP
Ages 16-25

The Prop 63 Youth Focus Group has determined that Wrap-Around Services (WAS) should be the primary focus for the use of available funds for this age group. We wish to emphasize the need for services for this age group. Wrap around services should address serious mental health issues presently seen at “first “ points of contact including a) Spirit House, b) County Mental Health (Nevada County Behavioral Health- NCBH), c) Law Enforcement contact, d) Schools, e) Self and/or family referral.

We also recommend that WAS hire a qualified person who will organize and advocate by determining and prioritizing each potential person’s need for WAS, and facilitating referral to agencies/support services including peer support services which can best help meet the needs of the client and to coordinate services with those agencies.

A part of the intent of the Youth Focus Group was to stress and emphasize the importance of Peer Support Services (PSS). The Youth Focus Group has determined that a portion of the Prop 63 funding should seek out, support, and train consumers to become peer counselors. While we realize that Spirit House already has existing groups we are stressing the importance of special needs of this population who historically are active in existing helping structures.

Of equal importance to the concept of WAS to the Youth Focus Group was the need for a counselor at both Juvenile Hall and Wayne Brown (Jail?) to serve the 18-25yo population.

Goals for the future include a Family Resource Center which could grow out of WAS and PSS as well as the development of an integrated approach to the problem of Dual Diagnosis and Co-occurring Disorders which could also grow out of WAS and PSS. Of importance but of lesser priority were recruitment of a Board Certified Child Psychiatrist and attention to need for mental health issues education for teachers. Having Mental Health counselors in the schools was also considered important but of lesser priority than the above.
MENTAL HEALTH SERVICES ACT (Proposition 63)  
FOCUS GROUP MEETING NOTES #3  
Charis Youth Center, Grass Valley  
August 8, 2005 (5:00 p.m. to 7:00 p.m.)

YOUTH

Those in attendance included Kathy Stone, Rich Stone, Teresa Martinez, Mary Folck, Lael Walz, Joan Rogers-Toensing, Donna Rogers, James Brunet, Corinne Gelfan, David Albertson, Ellen MacDonald, Judy Kerns, Drew Skeen, Karl Snyder, Karla Nix, Carol Fuller Powell, and Doug Loutzenhiser.

Discussion took place and the following focus group priorities were identified:

- Board certified child and adolescent psychiatrist (willing to diagnose bipolar in adolescents).
- Family Resource Center (future goal).
- Wrap around support.
- Training for teachers and administrators (change the culture with respect to mental illness). "Low" priority.
- Family advocate.
- Peer facilitation and support. High Priority.
- Counselor in Juvenile Hall.
- Integrated services for those with dual diagnosis.

Drew Skeen, Ellen MacDonald, Jim Brunet, and Joan Rogers-Toensing agreed to work on a proposal from the Youth Focus Group to the MHSA Steering Committee. The draft will be approved and finalized using group email. If additional focus group meeting is needed, it will be held on Monday, August 22, 2005, 5:00 p.m. at Charis Youth Center in Grass Valley.

As members of the MHSA Steering Committee, the group selected Drew Skeen and Rich Stone. Karla Nix can be a back-up alternate.
MENTAL HEALTH SERVICES ACT
NEVADA COUNTY
ADULT FOCUS GROUP RECOMMENDATIONS
September 1, 2005

PURPOSE:
The Nevada County Mental Health Services Act (MHSA) Adult Focus Group has met three times to gather input from the community on the mental health Community Support Services (CSS) needed for the treatment of unserved or underserved adults (ages 25 to 60) who have or may have persistent and severe mental illnesses, and to prioritize these services. The output from the Adult Focus Group, as well as other focus groups, will be submitted in the form of recommendations to the Nevada County MHSA Steering Committee for their use in formulating an overall recommendation plan for implementing MHSA Community Support Services in Nevada County. The purpose of this document is to submit these MHSA Adult Focus Group recommendations.

RECOMMENDATIONS:

NOTE: The below stated recommendations are of equal priority, irregardless of numbered sequence.

- Establish a Program of Assertive Community Treatment (PACT) team(s) in accordance with Reference 3.
- The PACT team(s) shall be structured to the unique needs of the Nevada County target population in accordance with the following minimum criteria, subject to available funding.
  - Fidelity to the Reference 3 PACT model is essential for assuring successful outcomes.
  - The PACT team(s) shall be community-based, mobile, multidisciplinary, highly trained mental health teams which use a client-to-staff ratio of no more than 10 clients per team member.
  - The team members shall include expertise for co-occurring (dual) diagnoses (substance abuse as well as serious mental illness).
  - The team members shall include client peers who are trained for their specific roles on the team.
  - Client peer team members shall be paid for their services consistent with their education, qualification and skills, the same as all other team members (except the unique knowledge and skills of the client peer team members shall be acknowledged).
  - Client peer team members shall participate in initial contacts whenever possible and appropriate (client trust in the credibility and integrity of the team is essential).
  - Target population (suggest a minimum of 30 clients) are those who are expected to meet the criteria established in the MHSA (References 1 & 2) and Laura’s Law (AB1421, Reference 4).
  - Crisis prevention and early intervention among the unserved and underserved is the initial, primary goal.
  - Outreach and treatment shall be provided as needed to the individual where he lives whenever possible.
  - Services shall be offered within the community to the extent possible.
  - Services offered shall be voluntary, however all who meet criteria are eligible for services regardless of legal status (e.g., court ordered services for clients through the Mental Health Court, Laura’s Law and LPS Conservatorship are eligible).
  - Offering of services shall be persuasive and assertive.
  - The treatment plan and services offered shall be tailored to the unique needs of the individual.
  - Integrated medical services shall be offered for all medical needs, not just for mental illness.
  - The fundamental needs for food, clothing and shelter must be addressed as well as the medical needs.
  - The team shall provide assistance in accessing existing county services whenever possible, for the vocational, educational, housing, co-occurring diagnoses and other special needs of the client. Funding shall be provided for liaison services between team members/clients and these other existing county services.
  - The client and family members shall participate in the establishment and ongoing review and assessment of treatment plans.
  - The team shall be monitored and held accountable for its actions through the implementation of written operating procedures and record keeping requirements.
Fund and expand existing peer counseling and other client-directed services (such as those offered by SPIRIT Peers for Independence and Recovery). In addition to supporting the PACT team(s) as specified in Recommendation 1, above (including client participation as team members on the PACT team(s)), these services would include the following as examples.

- Mobile outreach (this is an extension of the PACT mobile team(s), and separate).
- Drop-in center — a safe place to visit and seek refuge, socialization, peer counseling, one-on-one and group sessions, resource information and referral on available community services, all via peer-to-peer direct personal or phone contact, including follow-up contacts.
- Promote hope, personal self-empowerment, respect, social connections, self-responsibility and self-determination.
- Educate the community on serious mental illnesses to help fight stigma and discrimination.

Establish a mobile Crisis Intervention Team (CIT) for immediate response to crisis situations that could result in harm to self or others.

- CIT members shall include a law enforcement officer trained in mental health crisis intervention and a professional mental health crisis worker (could be a member of the PACT team(s)).
- The mobile CIT shall be available 24 hours/7 days per week, including backup staff as needed.

**BACKGROUND:**
The current Nevada County mental health system, administered under the County Behavioral Health Department (BHD), has limited funding, resources and facilities. There are no psychiatric inpatient facilities or long term residential care facilities, hence clients must be placed out-of-county for these services, at significant cost to the County and added stress for the client and family members. Because of the limited funding and consequential high client-to-staff ratios, in-county services are limited to an outpatient clinic and day treatment center. Clients receive outpatient treatment services only by visiting the clinic, where visit frequency and duration is limited. Initial contact at the clinic usually results only in the later (two weeks or more) scheduling of an appointment. Unless the client presents as an immediate danger to self or others there is limited acknowledgement of the extreme difficulty experienced by the client in even making it to the clinic for that initial contact. Clients who present only as depressed and/or anxious are often turned down for county mental health services, though their symptoms may actually reflect more severe and persistent serious mental illnesses. There are minimal outreach services. Consequently, many of our seriously mentally ill client population are treated inappropriately, under-treated or not treated at all, and many are homeless. The general response of the mental health system is reactive when it should be proactive, striving towards prevention and early intervention rather than crisis intervention. Meaningful transformation of our mental health system must include more training and an attitude adjustment for mental health management and staff.

Emergency response to mental illness crisis situations is usually handled by local law enforcement, assisted by follow-up, on-call psychiatric crisis response by mental health professional staff. Clients in crisis are usually taken to the county hospital emergency rooms (Sierra Nevada Memorial Hospital/Tahoe Forest Hospital — no psychiatric services), to county jail (Wayne Brown Correctional Facility) or to the BHD Outpatient Clinic (during week days) for evaluation and disposition. Lacking either an inpatient psychiatric hospital facility or a crisis intervention center, clients must wait for out-of-county placement, be held in jail or released back into the community, only to recycle again and again. This process is inefficient, costly and often does not serve the needs of the individual in need of treatment.

There is essentially no county program to address the special needs of those seriously mentally ill who also have a co-occurring diagnosis (COD) of substance abuse/addiction (also commonly called dual diagnosis). Yet BHD estimates that 80% to 90% of the mentally ill population in this county have COD addiction problems, and an integrated system of care is needed to address this specific population.
SPIRIT, a group from the local population of recovering clients with serious mental illnesses, has formed a non-profit, volunteer organization which provides trained peer counseling and other direct peer-to-peer support services, including a drop-in center, with only some minimal staff and funding support from BSHD. This organization is called SPIRIT, Inc., Peers for Independence and Recovery. The SPIRIT Center operates only 20 hours per week, because of limited staff and funding, yet it has already demonstrated the successful effect that direct support services to clients by other, trained and recovering clients can have. Their theme is self-determination and self-empowerment, and it works. The MHSA Adult Focus Group believes that SPIRIT should be expanded and funded, consistent with the “Recovery Vision” goals of the MHSA for consumer participation in the transformed mental health system. Client peers bring a source of expertise to the county mental health delivery system that is both effective and unique, because it cannot be duplicated regardless of training.

There are several community agencies (such as CORR, Food Ministry, Hospitality House, Sierra Nevada Memorial Hospital, Tahoe Forest Hospital, Miners Community Clinic, Sierra Family Medical Clinic, FREED, PRIDE, faith communities, NAMI, SPIRIT, etc.) which provide essential services such as food and housing assistance, general medical services, educational assistance, vocational assistance, help for people with disabilities, recovery resources for substance abusers, support and counseling services for the mentally ill and their families, etc. The need is to create more integration and interdependence among and between these community agencies and the mental health system, as well as other county agencies, to ensure that clients with serious mental illnesses have access to all of these much needed services.

DISCUSSION:
The Adult Focus Group discussed many additional mental health service needs for the community, including a crisis intervention center, more housing (a continuum of housing: homelessness shelters, a “23-hour” crisis bed facility, short term, transitional and long term residential care, supported independent living, a peer “village” complex emphasizing self reliance and mutual support, etc.), in-county psychiatric hospital facilities, a detox facility, and expanding facilities as well as services at the SPIRIT Center (perhaps in conjunction with a crisis intervention center). Because this initial recommendation is focused primarily on essential expenditures for services and personnel costs, recommendations for training, capital expenditures and other facility and equipment expenses are being deferred for future MHSA planning phases.

REFERENCES:
1. The Mental Health Services Act (MHSA, Proposition 63), passed by the state voters in November 2004.
3. The NAMI PACT MODEL of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses, a Manual for PACT Start-Up, 1998, by Deborah J. Allness, M.S.S.W. and William H. Knoedler, M.D.
4. Laura's Law (AB1421), Assertive Community Treatment with Assisted Outpatient Treatment, passed by the state legislature in 2002.
The two undersigned, members of the Adult Focus Group, are not in full agreement with the final and submitted MHSA “Adult Focus Group Recommendations – August 29, 2005.”

We feel that PACT was over-emphasized and SPIRIT was under-emphasized in the “Adult Focus Group Recommendations” compared to discussions at the August 10th Adult Focus Group meeting.

We believe that the effectiveness of SPIRIT and its continuing services now provides much of what the PACT model is intended to provide. SPIRIT can and will operate more economically and serve more people for a given amount of money. SPIRIT would rely on external resources such as Nevada County Behavioral Health, Miners Clinic, Sierra Family Medical Clinic, etc. for professional help, as needed. SPIRIT has its own and growing outreach component.

We recommend SPIRIT’s MHSA proposal but not the PACT program. We feel that other members of the Adult Focus Group would concur with this and an empowerment approach toward recovery.

Grass roots operation: It is important that supporters and the community understand the healing power that comes from peer-to-peer encounters with clients. This defines SPIRIT, its training, and counseling methods.

Digger Daniels
Cathy Renee
Mental Health Services Act
Senior Focus Group Paper

The Mental Health Services Act (MHSA) requirements are based on a logic model that links: 1) community issues resulting from untreated mental illness and a lack of services and supports, 2) mental health needs within the community, 3) the identification of specific populations to be served based upon the issues and needs identified, 4) the strategies and activities to be implemented and 5) the desired outcomes to be achieved. MHSA has identified one of its major goals as a reduction of the long-term adverse community impacts of untreated mental illness and serious emotional disorders.

Based upon the information that came from the collaborative efforts of the members of the Senior Focus Group the three most important issues facing seniors are:

- Dementia and Mental Health
- Grief
- Respite

In addition, the Senior Focus Group makes the recommendations to the Steering Committee based on the following assumptions regarding the mental health needs of older adults:

1) Recognition in Nevada County that Dementia is a mental illness. It is recognized as such in the DSM-IV under the general 290.0+ coding. It often has a comorbidity of clinical depression and primary caregivers often develop clinical depressive symptoms as a result of their caretaking activities.

2) Recognition that older adults may suffer from significant issues of clinical depression that is under-reported and under-treated. Recognition that significant cultural norms prevent this cohort from reaching out for help.

3) Grief and Loss are significant mental health issues for this age group. Loss of independence, spouse, friends, health issues, loss of physical abilities, isolation and the recognition of impending death trigger an existential crisis of integrity vs. despair.

4) Older adults present with complex physical and emotional needs that directly affect their mental status. Drawing arbitrary lines regarding what is organic vs. mental is not helpful to the needs of this population. Research continues to expose the organic underpinnings of many of the classic mental illness, e.g. schizophrenia. Inclusive, holistic approaches that treat the individual’s suffering are needed.

5) The establishment of a coordinated protocol for emergency response between Law Enforcement, Adult Protective Services, Behavioral Health, the Hospital and local housing facilities – includes assisted care facilities.
Recommendations – Community wide Need

1) Create an Emergency Psychiatric Response Team comprised of a Law enforcement officer and a mental health specialist able to respond to calls.
2) Culturally sensitive outreach, education, peer group support for transitional issues.

Recommendations – Senior Specific

Dementia, Grief and Mental Health
1) Clearing house with advocate to direct people to respite, daycare, side services, grief support, hospice, education, support older adults with dementia and psychiatric emergencies which covers a wide range of services with access to referrals 24 hours a day.
2) Geriatric Psychiatrist and emergency response clearing house based on an advocacy model (possibly through the emergency response team)
3) Create a multiple agency protocol for responding to mental health emergencies of older adults.
4) Drop in counseling center available once a week for seniors outside of the behavioral health building. Have this service provide both professional individual services and peer support groups. Have this service housed in a multipurpose community center as available.
5) Fund, subcontract, leverage funds to existing agencies that have the expertise and training to provide new services or expanded services to older adults. E.g., Hospice, Alzheimer’s Outreach Project, Minor’s Clinic.
6) Create a computer accessible client record, e.g. LifeLedger that can be used by multiple agencies to access history and coordinate care for older adults.

Respite
1) Provide ongoing respite services through adult day programs for caregivers on a regular basis.
2) Provide emergency respite money for overnight and weekend placement of older adults in crisis.

Definitions:

Culturally Sensitive = Recognizes that cultural issues are not just about ethnic origin or religious differences, but also include the norms and values that a generational cohort may possess. These generational values and norms may both help and hinder clinical interventions. A cultural norm that stresses self-sufficiency may keep an elder adult from getting help for a severe clinical depression.
Dementia = A level of cognitive impairment as reported by self, family, primary caregiver or other individual close to the patient. Does not require an evaluation by a psychiatrist, or declaration by the individual's primary health care provider to determine accuracy of the label. A study in the J Am Board Fam Prac 2005;18(4):240-256 found that questionnaires completed by family caregivers about patients were able to differentiate reliably between patients with dementia with a variety of degenerative disorders and patients without dementia with other neurological disorders that often are mistaken for dementia.

Respectfully submitted,

The Senior Focus Group

12+3